The Lower Extremity Functional Scale

Patient Name: _____ Date: _____

Instructions: We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your **LOWER LIMB** problem for which you are currently seeking attention. Please provide **ONE** answer for **EACH** activity.

Today, <u>do you</u> or <u>would you</u> have any difficulty at all with:

Activities (Circle **ONE NUMBER** on each line)	**Extreme Difficulty or Unable to Perform Activity**	**Quite a Bit of Difficulty**	**Moderate Difficulty**	**A Little Bit of Difficulty**	**No Difficulty**
Any of your usual work, housework, or school activities	0	1	2	3	4
Your usual hobbies, re creational or sporting activities	0	1	2	3	4
Getting into or out of the bath	0	1	2	3	4
Walking between rooms	0	1	2	3	4
Putting on your shoes or socks	0	1	2	3	4
Squatting	0	1	2	3	4
Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
Performing light activities around your home	0	1	2	3	4
Performing heavy activities around your home	0	1	2	3	4
Getting into or out of a car.	0	1	2	3	4
Walking 2 blocks	0	1	2	3	4
Walking a mile	0	1	2	3	4
Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
Standing for 1 hour	0	1	2	3	4
Sitting for 1 hour	0	1	2	3	4
Running on even ground	0	1	2	3	4
Running on uneven ground	0	1	2	3	4
Making sharp turns while running fast	0	1	2	3	4
Hopping	0	1	2	3	4
Rolling over in bed	0	1	2	3	4