Date:______________ Dr.______________ Patient:___________________________________ #_____

_____ LOWER EXTREMITY FUNCTIONAL SCALE (LEFS)

Patient Questionnaire

Please provide an answer for each activity as it relates to your lower extremity pain. Please circle:

Activities	Extreme difficulty or unable to perform	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, recreational, 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 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 1 mile	0	1	2	3	4
Going up or down 10 stairs (about 1 flight)	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	0	1	2	3	4
Hopping	0	1	2	3	4
Rolling over in bed	0	1	2	3	4

Please rate the severity of your pain RIGHT NOW by circling a number below:

No Pain | 0 1 2 3 4 5 6 7 8 9 10 | Worst pain imaginable

Please rate the severity of your pain AT THE WORST it has been in the last week:

No Pain | 0 1 2 3 4 5 6 7 8 9 10 | Worst pain imaginable

Score: _________/80 = _______%

Patient Signature:____