

## LOWER EXTREMITY FUNCTIONAL INDEX

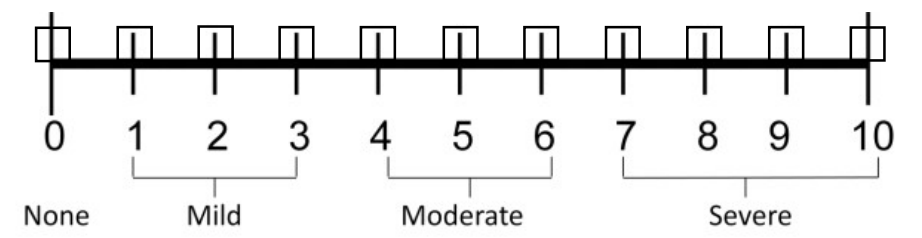
Patient Name: \_\_\_\_\_

Today's Date: \_\_\_/\_\_\_/\_\_\_

*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 answer for each activity.*

<b>Today, <u>do you</u> or <u>would you</u> have any difficulty at all with:</b>	<b>EXTREME DIFFICULTY OR UNABLE TO PERFORM ACTIVITY</b>	<b>QUITE A BIT OF DIFFICULTY</b>	<b>MODERATE DIFFICULTY</b>	<b>A LITTLE BIT OF DIFFICULTY</b>	<b>NO DIFFICULTY</b>
	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
	A. Any of your usual work, housework or school activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Your usual hobbies, recreational or sporting activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Getting into or out of the bath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Walking between rooms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Putting on your shoes or socks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Lifting an object, like a bag of groceries from the floor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Performing light activities around your home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Performing heavy activities around your home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Getting into or out of a car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Walking 2 blocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Walking a mile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. Going up or down 10 stairs (about 1 flight of stairs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N. Standing for 1 hour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O. Sitting for 1 hour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P. Running on even ground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q. Running on uneven ground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R. Making sharp turns while running fast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S. Hopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T. Rolling over in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*On the scale below please rate from 0 (no pain) to 10 (worst imaginable) the level of pain that best reflects the pain you are experiencing with your condition.*



<b>PROVIDER USE ONLY</b>				
Add column totals (eg., if there are 3 responses in the 2column – your total would be 6)				
0	1	2	3	4
Add total of the responses above				
LEFS Score = _____ / 80				