Solutions PHYSICAL THERAPY

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Lower Extremity Functionality Scale:

Last Name: __________________ First Name: _________________ Date: __________ Patient #: _________

We are interested in knowing whether you are having any difficulty with the activities listed below because of your lower limb problem for which you are currently seeking attention. Provide an answer for each activity.

Today, do you or would you have any difficulty with: (Circle one number on each line)

	Activities	**Extreme difficulty or unable to perform activity**	**Quite a bit of difficulty**	**Moderate difficulty**	**A little bit of difficulty**	**No difficulty**
A	Any of your usual work, household, or school activities	0	1	2	3	4
B	Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
C	Getting into or out of the bath.	0	1	2	3	4
D	Walking between rooms.	0	1	2	3	4
E	Putting on your shoes or socks.	0	1	2	3	4
F	Squatting.	0	1	2	3	4
G	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
H	Performing light activities around your home.	0	1	2	3	4
I	Performing heavy activities around your home.	0	1	2	3	4
J	Getting into or out of a car.	0	1	2	3	4
K	Walking 2 blocks.	0	1	2	3	4
L	Walking a mile.	0	1	2	3	4
M	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
N	Standing for 1 hour.	0	1	2	3	4
O	Sitting for 1 hour.	0	1	2	3	4
P	Running on even ground.	0	1	2	3	4
Q	Running on uneven ground.	0	1	2	3	4
R	Making sharp turns while running fast.	0	1	2	3	4
S	Hopping.	0	1	2	3	4
T	Rolling over in bed.	0	1	2	3	4
	PT USE ONLY: Column Totals:					
	Score is the sum of all circled items. (range = 0-80)				Score: (out of 80)	

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