

THE LOWER EXTREMITY FUNCTIONAL SCALE

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 an answer for each activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
Column Totals:						

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: _____ / 80

Please submit the sum of responses to ACN.
 Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, *The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application*, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.



Pain Diagram and Rating

Name: _____

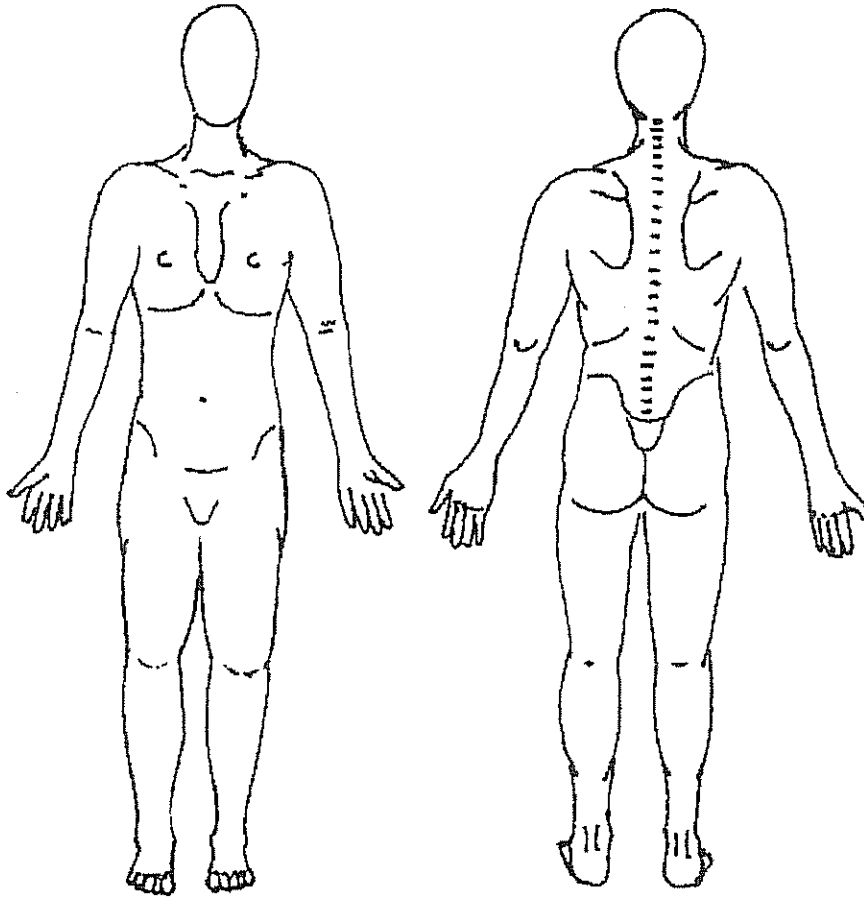
Date: ____/____/____
mm dd yy

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Use the key to indicate the type of symptoms.

Key:

Pins and Needles = 000000
Burning = xxxxxx

Stabbing = // // // // //
Deep Ache = zzzzzz



Chief Complaint:

- Pain
- Soreness
- Swelling
- Stiffness
- Locking
- Instability
- Weakness
- Numbness/Tingling
- Restricted Motion
- Other

Please rate your current level of pain on the following scale:

0 1 2 3 4 5 6 7 8 9 10

(no pain)

(worst imaginable pain)

Please describe your pain:

- Sharp Burning Spasm Dull Radiating Soreness
- Achy Numbness/Tingling Fatigue Other _____

Please describe your pain:

- Constant Occasional Intermittent During Rest During Activity
- Following Activity Night Pain Other _____

Please Turn Over