Lower Extremity Functional Scale

Patient Name: ____ Date: ____________________

PLEASE READ: 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 check an answer for each activity.

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

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

Patient Signature: ____