

## 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
<b>Column Totals:</b>						

Minimum Level of Detectable Change (90% Confidence): 9 points    SCORE: \_\_\_\_ / 80

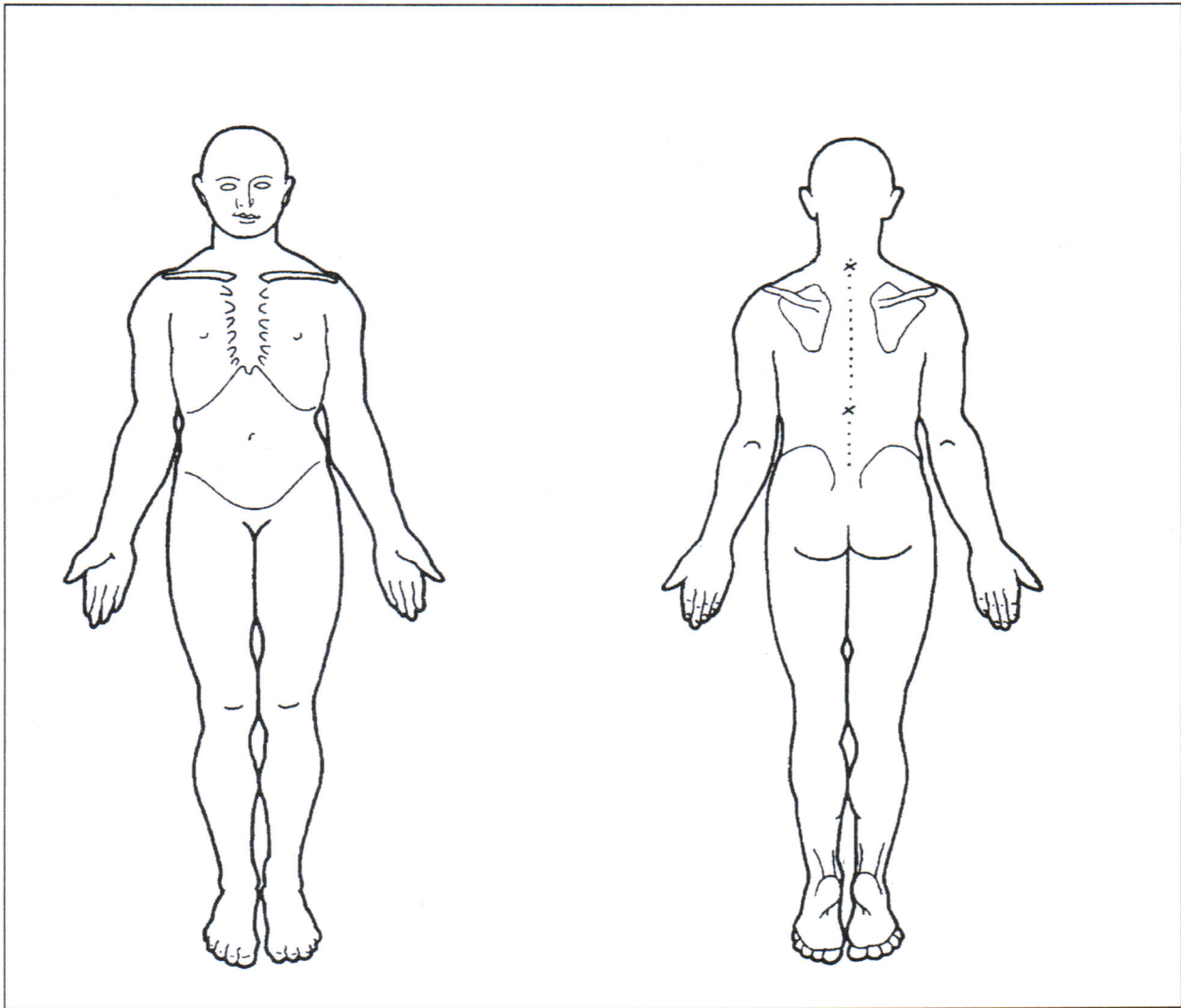
**Source:** Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. *Physical Therapy*. 79:371-383.

Name:

Signature:

Date:

Please use the drawings below to indicate where you feel symptoms right now.  
Shade in all areas where you feel pain.



Please use the three scales below to rate the intensity of your pain over the past **24 hours**. Use the upper number scale to describe your pain right now. Use the middle scale to describe the worst pain you have experienced since this time yesterday. Use the lower scale to describe the least amount of pain you have felt since this time yesterday.

<b>Rate Your Pain</b>	<b>0= No Pain</b>											<b>10= Severe Pain</b>										
Right Now	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Worst in 24 Hours	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Least in 24 Hours	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10