Name _____ **Date** _____

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 (circle 1 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, housework, 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
Column Totals:					

SCORE: _____/ 80

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

Binkley, J., Stratford, P., Lott, S., et al. The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Phys Ther: 79:4371-83, 1999.

Pain Numeric Rating Scale

1. On a scale of 0 to 10, with 0 being no pain at all and 10 being the worst pain imaginable, how would you rate your USUAL level of pain during the last week?

Please rate your pain

2. On the same scale, how would you rate your BEST level of pain during the last week?

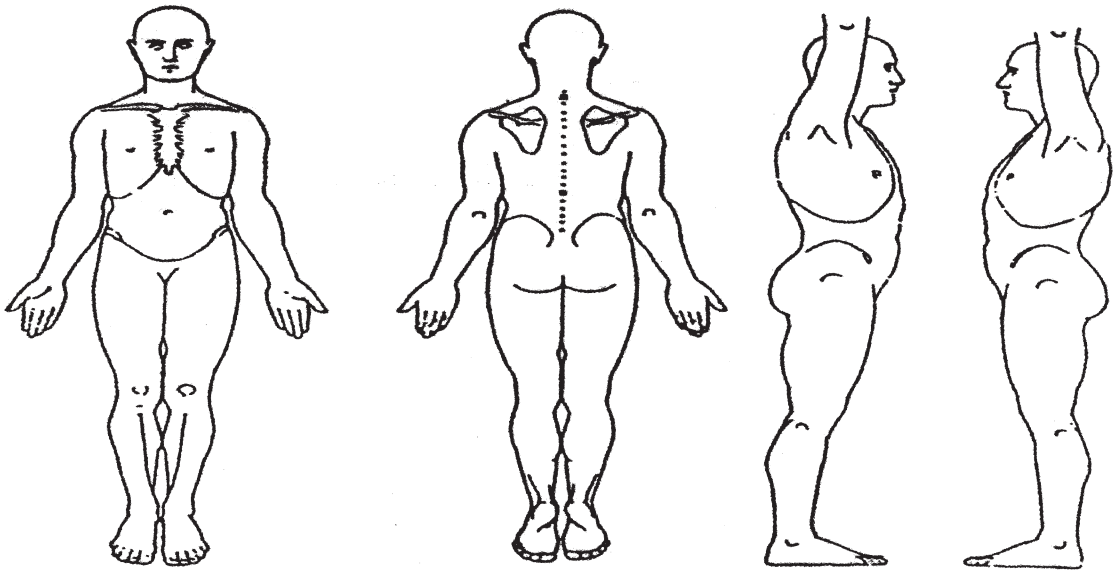
Please rate your pain

3. On the same scale, how would you rate your WORST level of pain during the last week?

Please rate your pain

LOCATION OF SYMPTOMS:
At present, mark exactly where you have your discomfort,

✓ ✓ ✓ Minimal to Moderate Pain
■ ■ ■ Severe Pain
→ → → Radiating Pain
X X X Numbness



When your problem began, was your discomfort in exactly the same location as you have it now? If the position of the discomfort has changed, how did the position of the discomfort progress from the original location? _____

FORM #BP50056