

LOWER EXTREMITY FUNCTIONAL SCALE | HIP, KNEE FOOT & ANKLE

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
Any of your usual work, housework, or school activities.	0 🗆	1 🗆	2 🗖	3 □	4□
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 🗆
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.	0 🗖	1 🗆	2 🗆	3 □	4 🗆
19. Hopping	0 🗖	1 🗖	2 🗖	3 🗖	4 □
20. Rolling over in bed.	0 🗖	1 🗆	2 🗖	3 🗅	4 🗅
Column Totals:					

17. Hurling on uneven ground.			1 3	2 🗓	3 🗖	4 🖵			
18. Making sharp turns while running.	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									
Therapist Name:		9	Score:						
Date:	D/C	5	Score = Sum or responses ÷ Number possible x 100						
76 Bedford Street Suite 7 Lexington, MA 02420 T 781.862.0200 T 781.862.0600 info@GlynnPT.com www.GlynnPT.com									



Name	
Date	

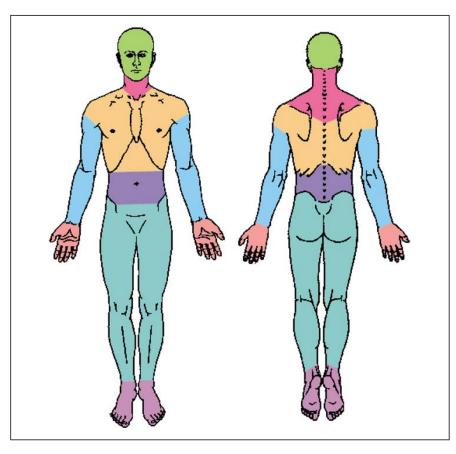
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PAIN DIAGRAM AND RATING

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. You may also fill this part out at the time of your visit.

Key: Pins and Needles = 00000 Stabbing

Burning = xxxxx Deep Ache = zzzzzz



Please rate	e your <i>cur</i>	rent level	of pain on	the followir	ng scale (d	check one)				
0 ☐ (no pain)	10	2 🗖	3□	4 🗖	5□	6□	7🗆	8□	9□ (worst in	10 □ naginable pain)
Please rate	e your wo	rst level of	f pain int th	e last 24 h	ours on th	e following	scale (ch	eck one)		
0 □ (no pain)	10	2 🗖	3□	4□	5□	6□	70	8□	9□ (worst in	10 □ naginable pain)
Please rate	e your <i>be</i> s	at level of	pain in the	last 24 hou	ırs on the	following s	cale (chec	ck one)		
0 □ (no pain)	10	2 🗖	3 □	4 🗆	5 🗖	6□	7 🗆	8□	9 □ (worst in	10 □ naginable pain)
Therapist Na	ame:									
Date:			I/E F	/U D/C						