GLYNN
PHYSICAL THERAPY

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
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.	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: _____

Date: _____ **I/E** **F/U** **D/C**

Score:_____

Score = Sum or responses ÷ Number possible x 100

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PATIENT IDENTIFICATION AREA

Name_____

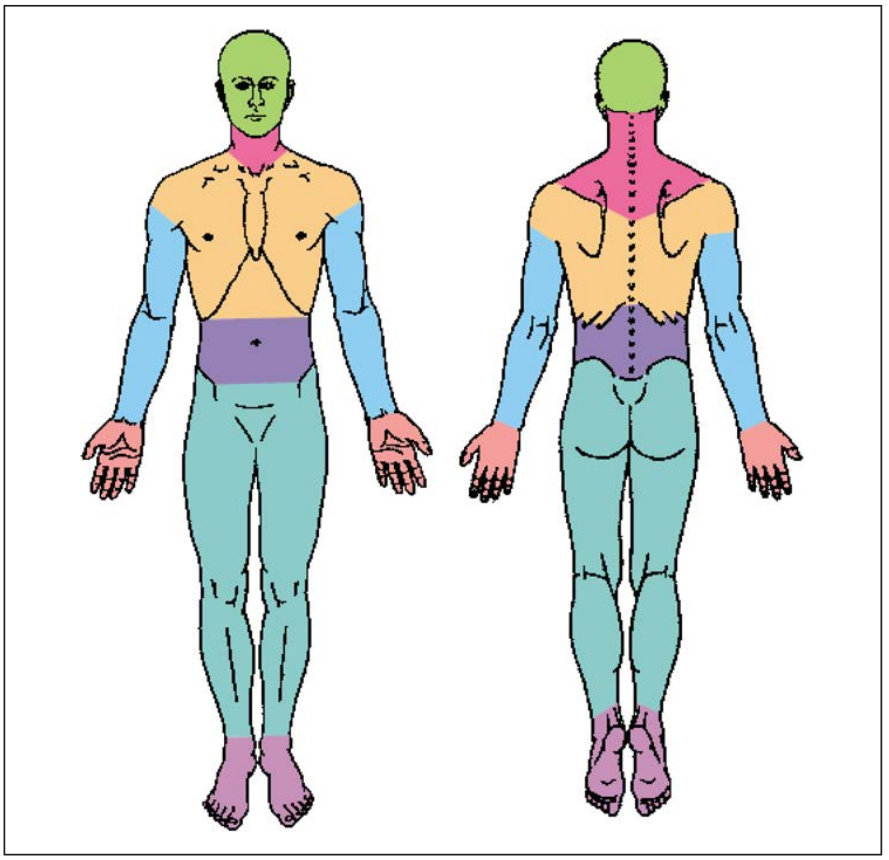
Date_____

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 your *current* level of pain on the following scale (check one)

0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑

(no pain) (worst imaginable pain)

Please rate your *worst* level of pain int the last 24 hours on the following scale (check one)

0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑

(no pain) (worst imaginable pain)

Please rate your *best* level of pain in the last 24 hours on the following scale (check one)

0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑

(no pain) (worst imaginable pain)

Therapist Name:_____

Date: _____ I/E F/U D/C

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