

Name: _____ Date: _____

Lower Extremity Functional Scale

We are interested in knowing whether you are having any difficulty with the activities listed below **because of your lower limb** problem for which you are currently seeking attention. Provide an answer for each activity.

Today, **do you** or **would you** have any difficulty with: (Circle one number on each line)

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

FOR OFFICE USE ONLY

Column totals:	_____	+	_____	+	_____	+	_____	+	_____
Total: _____									