

**LEFS FORM**  
**LOWER EXTREMITY FUNCTIONAL SCALE**

Thank you for completing this patient-reported outcome questionnaire. Your responses help your provider determine the best treatment options and track your recovery progress over time. Please answer each of the questions included on this form.

**NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

**DID YOU HAVE SURGERY FOR THIS ISSUE PRIOR TO RECEIVING THERAPY?**

YES

NO

**PAIN SCORE: OVER THE PAST 24 HOURS, HOW BAD HAS YOUR PAIN BEEN?**

CIRCLE THE NUMBER THAT BEST REPRESENTS YOUR PAIN:

NO PAIN    0    1    2    3    4    5    6    7    8    9    10    WORST IMAGINABLE PAIN

**TODAY, DO YOU OR WOULD YOU HAVE ANY DIFFICULTY AT ALL WITH:**  
FOR EACH ROW, MARK THE ONE BOX WHICH MOST CLOSELY DESCRIBES YOUR CURRENT CONDITION.

	EXTREME DIFFICULTY OR UNABLE TO PERFORM	1	2	3	4
1. ANY OF YOUR USUAL WORK, HOUSEWORK, OR SCHOOL ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. YOUR USUAL HOBBIES, RECREATIONAL OR SPORTING ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. GETTING INTO OR OUT OF THE BATH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. WALKING BETWEEN ROOMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. PUTTING ON YOUR SHOES OR SOCKS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. SQUATTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1. Injury onset or surgery date \_\_\_\_\_

2. Duration of pain (Check One):

Less than one month or no pain

1-3 months

More than 3 months

# LEFS FORM LOWER EXTREMITY FUNCTIONAL SCALE

**TODAY, DO YOU OR WOULD YOU HAVE ANY DIFFICULTY AT ALL WITH:**  
 FOR EACH ROW, MARK THE ONE BOX WHICH MOST CLOSELY DESCRIBES YOUR CURRENT CONDITION.

	EXTREME DIFFICULTY OR IMABILITY TO PERFORM	0	1	2	3	4
	QUITE A BIT OF DIFFICULTY	A LITTLE BIT OF DIFFICULTY	MODERATE DIFFICULTY	NO DIFFICULTY	NO DIFFICULTY	NO DIFFICULTY
7. LIFTING AN OBJECT, LIKE A BAG OF GROCERIES FROM THE FLOOR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. PERFORMING LIGHT ACTIVITIES AROUND YOUR HOME	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. PERFORMING HEAVY ACTIVITIES AROUND YOUR HOME	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. GETTING INTO OR OUT OF A CAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. WALKING 2 BLOCKS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. WALKING A MILE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. GOING UP OR DOWN 10 STAIRS (ABOUT 1 FLIGHT OF STAIRS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. STANDING FOR 1 HOUR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. SITTING FOR 1 HOUR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. RUNNING ON EVEN GROUND	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. RUNNING ON UNEVEN GROUND	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. MAKING SHARP TURNS WHILE RUNNING FAST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. HOPPING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. ROLLING OVER IN BED	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 Scores range from 0 (most severe disability) to 80 (no disability)