

In Motion Physical Therapy – Lower Extremity Functional Scale

Patient Name: _____ Date: _____

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 circle a number for **each** activity.

Today, do you or would you have any difficulty at all with:

	Extreme Difficulty	Quite a Bit of	Moderate	A Little Bit	No Difficulty
	or Unable to	Difficulty	Difficulty	of Difficulty	
Activities	Perform Activity				
1 Any of your usual work, housework, or school activities.	0	1	2	3	4
2 Your usual hobbies, re creational 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 fast.	0	1	2	3	4
19 Hopping.	0	1	2	3	4
20 Rolling over in bed.	0	1	2	3	4
Column Totals:					

Patient Signature: _____

Therapist Signature: _____