

LOWER EXTREMITY FUNCTIONAL SCALE (LEFS)

NAME _____

DATE _____ / _____ / _____

**PLEASE RATE YOUR PAIN LEVEL WITH ACTIVITY FROM 0 TO 10:
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 EXCRUCIATING PAIN)**

This survey is meant to help identify and quantify your level of function or deficit as it relates to your lower extremity issue. Please circle the answers below that best apply to your situation over the past week.

		Extreme Difficulty or Unable to Perform Activity (0)	Quite a Bit of Difficulty (1)	Moderate Difficulty (2)	A Little Bit of Difficulty (3)	No Difficulty (4)
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 fast	0	1	2	3	4
19.	Hopping	0	1	2	3	4
20.	Rolling over in bed	0	1	2	3	4