RESTORATIVE THERAPY & WELLNESS LLC

We restore your movement

The Lower Extremity Functional Scale

Name: _____ **Date:** _____

As a result of your lower limb problem for which you are currently seeking treatment, we are interested in knowing whether you are having any difficulty at all with the activities listed below. Please **circle the number next to each activity** that best describes your level of difficulty.

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

	Activity	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/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 vehicle	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 one 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:					

Minimum Level of Detectable Change (90% Confidence): 9 Points

SCORE: _____**/80**

Therapist Signature: _____

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