Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

LEFS- INITIAL VISIT

Please rate your pain level with activity: NO PAIN=0 1 2 3 4 5 6 7 8 9 10= VERY SEVERE PAIN

	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 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 and 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

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383

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Patient Name:_____ **Date:**_____

Age:_____ **Height:**_____ **Weight:**_____

How much pain do you have <u>today?</u> Please circle a number (0= no pain, 10= worst pain)

0 1 2 3 4 5 6 7 8 9 10

What medications are you currently taking? Please include prescription meds, over the counter meds, and supplements with names, dosage, and frequency. **<u>Please list below</u>**:

_____

_____

_____

Have you had two or more falls in the past year? (Please circle one): **Yes** **No**

Have you had an injury as a result of a fall in the past year? (Please circle one): **Yes** **No**

Who is your primary care physician?_____

When is the next time you are seeing a physician?_____

Did you have a specific injury or surgery for this problem? Yes **No** **Date(s):**_____

_____

Have you had any diagnostic tests for this problem? Yes **No** **Date(s):**_____

_____

Please list any other medical problems you have, or any other surgeries you have had?_____

_____

_____

What is your occupation?_____

Has your work schedule been modified because of this problem?_____

Are you living alone at this time?_____

What goal(s) would you like to accomplish with PT? _____