

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

Olympic Physical Therapy, LLC

Patient Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____

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

0 1 2 3 4 5 6 7 8 9 10

Please list below any medications you are currently taking. Please include prescription meds, over the counter meds, and/or supplements with names, dosage, and frequency.

Drug Name	Dosage	Frequency	Drug name	Dosage	Frequency
1.			4.		
2.			5.		
3.			6.		

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

Have you had two or more falls in the past year? **Yes** **No**

Who is your primary care physician? _____

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

Have you had any diagnostic tests for this problem? **Yes** **No** (If Yes, please list below):

Have you had a specific injury or surgery for this problem? **Yes** **No** (If Yes, please list below):

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

Are you currently employed? **Yes** **No** Job Title? _____

Has your work schedule been modified because of this problem? **Yes** **No**

Are you living alone at this time? **Yes** **No**

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

Please turn page over →