

Lower Extremity Functional Scale

REDCap ID _____

Visit date: _____

Patient Age _____

Visit type: Initial visit Medial visit
 Final visit
 (There should be only one Initial visit and one Final visit.)

Diagnostic Category

- ABI
- Amputation
- Breast Cancer
- Chronic Pain
- Elbow
- Foot/Ankle
- Gait/Balance
- Headache
- Hand/Wrist
- Hip
- Knee
- LE Lymphedema
- Low Back
- Lower Extremity
- Midback
- Neck
- Other Neuro
- Parkinsons
- Pediatric Other
- Pediatric/CP
- Pulmonary
- SCI
- Shoulder
- Speech
- Stroke
- Vestibular

Diagnostic Complexity Non-complex (Single Body Part Sprain/Strain)
 Complex (Multi-body part, fracture, nerve symptoms)
 Post surgical

Patient has had surgery for the current condition? Yes No

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 provide an answer for each activity.

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

Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
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Any of your usual work, housework, or school activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your usual hobbies, re creational or sporting activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting into or out of the bath.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking between rooms.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Putting on your shoes or socks.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squatting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting an object, like a bag of groceries from the floor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Performing light activities around your home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Performing heavy activities around your home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting into or out of a car.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking 2 blocks.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking a mile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going up or down 10 stairs (about 1 flight of stairs).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing for 1 hour.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting for 1 hour.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running on even ground.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running on uneven ground.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making sharp turns while running fast.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hopping.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rolling over in bed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please stop here and return the tablet or form to staff member.

Patient Score (For Staff Use)

Score ___(%) disability

_____ (Out of 80)

G Code:
CH

G Code:
CI

G Code:
CJ

G Code:
CK

G Code:
CL

G Code:
CM

G Code:
CN