



PHYSICAL THERAPY: LEFS Patient Questionnaire: HIP / KNEE

Today's Date: ____ / ____ / ____

Involved side Right Left Both

Injury Date (if known) ____ / ____ / ____ Surgery Date (if applicable) ____ / ____ / ____

Date you return to the physician who sent you to physical therapy ____ / ____ / ____

Occupation _____

Have you been given any restrictions by your physician? (please specify) _____

Please rate the severity of your pain RIGHT NOW by circling a number below:

No pain

0	1	2	3	4	5	6	7	8	9	10
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 Worse pain imaginable

Please rate the severity of your pain at the worst it has been in the last week:

No pain

0	1	2	3	4	5	6	7	8	9	10
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 Worse pain imaginable

What **SPECIFIC** activities do you hope to improve through physical therapy?

Lower Extremity Functional Scale (LEFS)

Instructions:

We are interested in knowing if you are having difficulty with the activities listed because of your leg problem for which you are seeking help. Please provide an answer for each activity listed on the following page:



PATIENT LABEL MUST
BE PLACED WITHIN
THIS BOX



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Activities	Extreme difficulty or unable to perform	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No Difficulty
Any of your usual work, housework, or school activities	0	1	2	3	4
Your usual hobbies, recreational, or sporting activities	0	1	2	3	4
Getting into or out of the bath	0	1	2	3	4
Walking between rooms	0	1	2	3	4
Putting on shoes or socks	0	1	2	3	4
Squatting	0	1	2	3	4
Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
Performing light activities around your home	0	1	2	3	4
Performing heavy activities around your home	0	1	2	3	4
Getting into or out of a car	0	1	2	3	4
Walking 2 blocks	0	1	2	3	4
Walking 1 mile	0	1	2	3	4
Going up or down 10 stairs (about 1 flight)	0	1	2	3	4
Standing for 1 hour	0	1	2	3	4
Sitting for 1 hour	0	1	2	3	4
Running on even ground	0	1	2	3	4
Running on uneven ground	0	1	2	3	4
Making sharp turns while running	0	1	2	3	4
Hopping	0	1	2	3	4
Rolling over in bed	0	1	2	3	4

Signature of person completing form _____

Reviewer _____

Date / Time _____

Score: _____ / 80 = _____ %



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