PERFORMANCE PHYSICAL THERAPY AND SPORTS REHABILITATION

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Lower Extremity Functional Index

Patient Name: _____ Date: _____

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 the difficulty at all with: (*Circle **one** number on each line*)

Activities	Extreme difficulty or unable to perform activity	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 your 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 a mile	0	1	2	3	4
Going up or down 10 stairs (about 1 flight of stairs)	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 fast	0	1	2	3	4
Hopping	0	1	2	3	4
Rolling over in bed	0	1	2	3	4
Column Total					

The Therapist will total all the columns

Score: ___/80

Pain Scale: Please place **TWO** circles on the scale below, one for your pain level at its worst in the last 48 hours and the other for your pain level at its best in the last 48 hours. (If you have had instances of no pain, circle 0 for best)

0 1 2 3 4 5 6 7 8 9 10

0 = No pain 5 = Makes you stop what you are doing 10 = Worst Pain imaginable, need to go to ER