**Therapy Center North Inc., DBA Therapy Center East**

**LEFS**

**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 circle the number in the box corresponding to the level of difficulty you have while doing the below activities.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Today, do you or would you have any difficulty at all doing the following: | 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, off 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 the 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 Totals:  |  |  |  |  |  |

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please Indicate your level of pain at the following times by placing a dash on the line that indicates where you rate your pain. The line begins with 0, indicating no pain, and ends with 10, indicating the worst pain imaginable.**

**When your pain is the lowest it can be:**

 No pain 0 10 Worst pain imaginable

**When your pain is the at its worst it can be:**

 No pain 0 10 Worst pain imaginable

**What your pain is right now:**

 No pain 0 10 Worst pain imaginable

**Please indicate the amount of improvement you have made since the beginning of your treatment:**

 None 0 10 Complete Recovery