THE LOWER EXTREMITY FUNCTIONAL SCALE

This questionnaire has been designed to give the doctor/physical therapist information as to how your lower limb has affected your ability to manage in daily life. Please answer every question by circling the number below the appropriate response. Please only mark ONE response per question.

	Today, do you or would you have any difficulty at all with:	EXTREME DIFFICULTY OR UNABLE TO PERFORM	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 or 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 the car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking 1 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

To be completed by physical therapist/provider only SCORE: __________/80

FOOT FUNCTION INDEX

This questionnaire has been designed to give your therapist information as to how your foot pain has affected your ability to manage in everyday life.

For the following questions, we would like you to score each question on a scale from 0 (no pain) to 10 (worst pain imaginable) that best describes your foot **over the past week**. Please read each question and place a number from 0-10 in the corresponding box.

SCALE FOR QUESTIONS 1-5: NO PAIN -0 1 2 3 4 5 6 7 8 9 10- WORST PAIN IMAGINABLE

1	In the morning upon taking your first step?	
2	When walking?	
3	When standing?	
4	How is your pain at the end of the day?	
5	How severe is your pain at its worst?	

Answer all of the following questions related to your pain and activities **over the past week**, how much difficulty did you have?

SCALE FOR 6-14: NO DIFFICULTY -0 1 2 3 4 5 6 7 8 9 10- SO DIFFICULT I AM UNABLE TO DO

6	When walking in the house?	
7	When walking outside?	
8	When walking four blocks?	
9	When climbing stairs?	
10	When descending stairs?	
11	When standing tip toe?	
12	When getting up from a chair?	
13	When climbing curbs?	
14	When running or fast walking?	

Answer all of the following questions related to your pain and activities **over the past week**, how much of the time did you:

SCALE FOR 15-17: NONE OF THE TIME -0 1 2 3 4 5 6 7 8 9 10- ALL OF THE TIME

15	Use an assistive device (walker, crutches) indoors?	
16	Use an assistive device (walker, crutches) outdoors?	
17	Limit physical activity?	

To be completed by physical therapist/provider.

SCORE: _________/170 x 100 = _________%