Sunnybrook
HEALTH SCIENCES CENTRE

Lower Extremity Functional Scale (LEFS)

Date (YYYY/MM/DD): _____

☐ Initial ☐ Discharge

PATIENT IDENTIFICATION

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

Activites	Extreme Difficulty or Unable to Perform Activity	Quite a bit of Difficulty	Moderate Difficulty	A Little bit of Difficulty	No Difficulty
a. Any of your usual work, housework or school activities.	○	○	○	○	○
b. Your usual hobbies, recreational or sporting activities.	○	○	○	○	○
c. Getting into or out of the bath.	○	○	○	○	○
d. Walking between rooms.	○	○	○	○	○
e. Putting on your shoes or socks.	○	○	○	○	○
f. Squatting.	○	○	○	○	○
g. Lifting an object, like a bag of groceries from the floor.	○	○	○	○	○
h. Performing light activities around your home.	○	○	○	○	○
I. Performing heavy activities around your home.	○	○	○	○	○
j. Getting into or out of a car.	○	○	○	○	○
k. Walking 2 blocks.	○	○	○	○	○
l. Walking a mile.	○	○	○	○	○
m. Going up or down 10 stairs (about 1 flight of stairs).	○	○	○	○	○
n. Standing for 1 hour.	○	○	○	○	○
o. Sitting for 1 hour.	○	○	○	○	○
p. Running on even ground.	○	○	○	○	○
q. Running on uneven ground.	○	○	○	○	○
r. Making sharp turns while running fast.	○	○	○	○	○
s. Hopping.	○	○	○	○	○
t. Rolling over in bed.	○	○	○	○	○
Column Totals: SCORE: _____/80					

 (90% Confidence Interval = ± 6) Minimum Detectable Change/ Minimal Clinically Important Difference: 9

☐ **Form completed by patient** **OR** **Name of person completing this form (PRINT NAME):**

_____

DPR60079

PR 60079
(2018/10/09)

The P4 Questionnaire

Date (yyyy/mm/dd): _____

When answering these questions, think **only** of **the pain** you are **experiencing in relation to the problem for which you are having an assessment.**

Check **one number** for each of the four questions.

On average, how bad has your pain been:

	No Pain										**Pain as bad as it can be**
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
In the morning over the past 2 days?	○	○	○	○	○	○	○	○	○	○	○
In the afternoon over the past 2 days?	○	○	○	○	○	○	○	○	○	○	○
In the evening over the past 2 days?	○	○	○	○	○	○	○	○	○	○	○
With activity over the past 2 days?	○	○	○	○	○	○	○	○	○	○	○

Score: _____ **/40**

NAME: _____

References

Spadoni GF, Stratford PW, Solomon PE, Wishart LR. The Evaluation of Change in Pain Intensity: A Comparison of the P4 and Single-Item Numeric Pain Rating Scales. J Orthop Sports Phys Ther, 2004: 34(4): 187-93.

Stratford PW, Dogra M, Woodhouse L, Kennedy DM, Spadoni GF. Validating Self-Report Measures of Pain and Function in Patients Undergoing Hip or Knee Arthroplasty. Physiother Can, 2009: 61; 189-194.