LEFS – INITIAL

Please select the answers below that best apply.

PATIENT NAME: ***DATE:***

	Extreme Difficulty or Unable	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 socks or shoes	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 a car	0	1	2	3	4
11. Walking 2 blocks	0	1	2	3	4
12. Walking a mile	0	1	2	3	4
13. Going up or down 10 stairs (1 flight)	0	1	2	3	4
14. Standing for 1 hour	0	1	2	3	4
15. Making sharp turns while running fast	0	1	2	3	4
16. Sitting for 1 hour	0	1	2	3	4
17. Running on even ground	0	1	2	3	4
18. Running on uneven ground	0	1	2	3	4
19. Hopping	0	1	2	3	4
20. Rolling over in bed	0	1	2	3	4

Please rate your pain level with activity

0 1 2 3 4 5 6 7 8 9 10

WHAT ARE YOUR MAJOR GOALS FOR PHYSICAL THERAPY:

Physical therapy by its nature involves physical activity including, hands on treatment, exercise, stretching and other modalities. While the ultimate goal of these treatments is to reduce your pain and improve your function the implementation of these treatments may temporarily exacerbate your symptoms or soreness. Should this become intolerable you always have the right to ask for treatment to be reduced. By signing below you agree with the above activity levels, goals and understand the above statement.

PATIENT SIGNATURE: ______________________________

Office use only: Patient ID #: ______________________ Therapist: ______________________