Name:_____	Initial □ Follow up □ Discharge □
Date:_____	Score:

LOWER EXTREMITY FUNCTIONAL INDEX

We are interested in knowing if whether you are having any difficulty at all with the activities listed because of your lower limb problem which you are currently seeking attention. We request that you complete this form on the date of your assessment in order to provide accurate results. Please provide an answer for each activity.

Today, do you or would you have any difficulty with:

ACTIVITIES	Extreme Difficulty Or Unable To Perform Activity 0	Quite a Bit of Difficulty 1	Moderate Difficulty 2	A Little Bit of Difficulty 3	No Difficulty 4
a. 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: _____/_____=_____
Percentage Score: _____/_____=_____%