

GILBERT PHYSICAL THERAPY

Affiliate of OPTN

Knee, Ankle, Foot Questionnaire

Lower Extremity Functional Scale

Patient Name: _____ D.O.B. _____ Date: _____

Activities Please rate the difficulty levels below by the way you are feeling today.	Extreme Or unable to perform Activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficult
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 from 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 a 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:

SCORE: _____ /80