

# LOWER EXTREMITY FUNCTIONAL QUESTIONNAIRE

Please answer each question and choose the response that most accurately describes your functional limitations *as they relate to your CURRENT lower extremity injury.*

Functional Activity	N/A (0)	Never (1)	Seldom (2)	Occasionally (3)	Frequently (4)	Always (5)
I have difficulty rising from a chair						
I have difficulty getting in and out of my car						
I have difficulty tolerating a standing position						
I have difficulty tolerating prolonged standing for greater than 30 minutes						
I have difficulty walking in my home						
I have difficulty walking 5 minutes or less						
I have difficulty walking approximately 10 minutes						
I have difficulty walking 20 minutes or greater						
I have difficulty walking on uneven surfaces						
I have difficulty performing household chores						
I experience instability, locking, or giving way of my knee, hip or ankle (circle one or all that apply)						
I lose my balance when walking or performing daily activities						
I have fallen due to my lower extremity injury						
I have difficulty walking up stairs						
I have difficulty walking down stairs						
I have difficulty squatting or kneeling						
I have difficulty sleeping through the night due to my lower extremity injury						
I have difficulty performing recreational activities (ie. Gardening, golfing, etc.)						
I have difficulty getting dressed (ie., bending over to put on socks / shoes etc.)						
<b>Total score/column (for therapist use only)</b>						

**Total score (for therapist use only): \_\_\_\_\_ /95**

**Please note any other functional limitations that were not addressed above:**

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Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_