

**PATIENT NAME:** \_\_\_\_\_ **ID#:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Description:** This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

1. Please rate your pain level with activity: NO PAIN = **0**   **1**   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**   **10** = VERY SEVERE PAIN
2. How satisfied are you with the level of care and service provided?   **Very Satisfied**   **Satisfied**   **Unsatisfied**   **Very Unsatisfied**
3. Please rate your progress with functional activities from start of therapy to this point in time.   **Excellent**   **Good**   **Fair**   **Poor**
4. At this point in your treatment, have your therapy goals been met?   **Completely Met**   **Mostly Met**   **Partially Met**   **Not Met**

## **LEFS – FOLLOW-UP AND DISCHARGE VISIT**

### **HIP / KNEE / ANKLE**

	<u>Extreme Difficulty or Unable to Perform Activity</u>	<u>Quite a Bit of Difficulty</u>	<u>Moderate Difficulty</u>	<u>A Little Bit of Difficulty</u>	<u>No Difficulty</u>
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 shoes or socks	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 (about 1 flight of stairs)	0	1	2	3	4
14. Standing for 1 hour	0	1	2	3	4
15. Sitting for 1 hour	0	1	2	3	4
16. Running on even ground	0	1	2	3	4
17. Running on uneven ground	0	1	2	3	4
18. Making sharp turns while running fast	0	1	2	3	4
19. Hopping	0	1	2	3	4
20. Rolling over in bed	0	1	2	3	4