Name: _____ **Lower Extremity Concern DOB:** _____ **Today's Date:** _____

Describe your primary condition: _____

When did this begin? _____ How did it begin? _____ Is this a recurrence? ☐Y ☐N

How has it changed since last episode / last exam ? ☐ N/A ☐ Same ☐ _____% Better ☐ _____% Worse

Describe previous treatments by other providers? _____ Did it help? ☐ Y ☐ N

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Other _____

How frequently are you affected by this condition? ☐ Constant ☐ Daily ☐ Intermittent ☐ Morning Only ☐ Night Only

☐ After a specific activity During a specific activity Describe: _____

How long does it last? ☐ All Day ☐ A Few Hours ☐ Minutes ☐ It Doesn't Stop

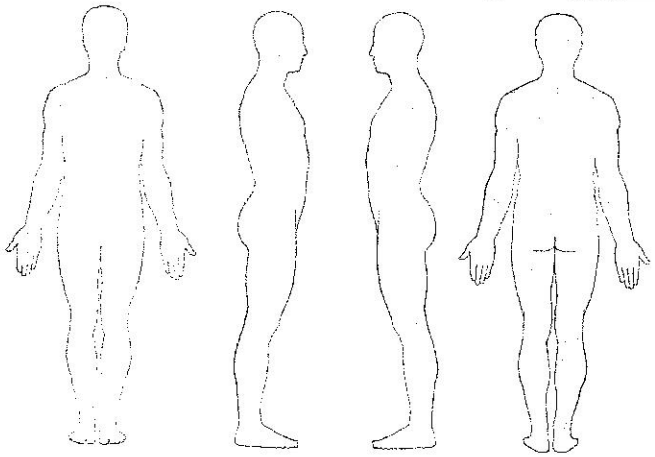
What makes it worse? ☐Sitting ☐Standing ☐ Lying ☐Walking ☐Getting up from chair ☐Bending ☐Lifting ☐Other _____

What are you having trouble doing now that you could do before? _____

What makes it better? And for how long? Describe: _____

Lower Extremity Functional Scale: **Because of your leg– hip / knee/ ankle, do you or would you have any difficulty at all with :**

	Activities	Extreme Difficulty or Unable to Perform Activity	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 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 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



On a scale of 1 to 10: rate your pain _____

Mark the areas of pain on this diagram.

Identify: S = Sharp A = Ache B = Burn W = Weak

N = Numb D = Dull T = Tingling

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