



## Lower Extremity Outcome Measure

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

This questionnaire has been designed to give your therapist information about how your injury has affected your ability to manage in everyday life. Please mark the (one) box which most closely describes your limitation.

0 = Extreme difficulty or unable to perform activity

1 = Quite a bit of difficulty

2 = Moderate difficulty

3 = A little bit of difficulty

4 = NO difficulty

1.	Any of your usual work, housework or school activities.	0	1	2	3	4
2.	Your usual hobbies, recreational, or sporting	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