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.**

LEFS – INITIAL VISIT

Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	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 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

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383.

Therapist Use Only

Comorbidities:
- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD Code: _____

Initial Intake Questionnaire

Body part being seen for:_____

Weight:_____ Height:_____

Date of injury:____/____/_____ Date of Surgery:_____/_____/____

Did your symptoms come on as a:

- Gradual process
- New Injury
- Chronic problem

Occupation:

Is the work load:

- Sedentary
- Light
- Medium
- Heavy

Primary concern/complaint:

What is your goal to achieve from physical therapy?

Pain rating: 0=No pain and 10=Severe, unrelenting pain that makes you unable to function at all

Worst (when you have the most pain): 0 1 2 3 4 5 6 7 8 9 10

Current (what it is now): 0 1 2 3 4 5 6 7 8 9 10

Best (when you have the least pain): 0 1 2 3 4 5 6 7 8 9 10

Describe your pain (Circle all that apply): Dull/Achy Sharp Throbbing Burning Shooting

Constant Intermittent

Medications (Please list or provide a list):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

I have provided my medication list to the best of my knowledge and will notify my therapist of any changes as they occur.

Signature:_____ Date:____/_____/_____

Past Medical History: Check all that apply

○ Alzheimer's ○ Cardiovascular Disease ○ Stroke ○ Current Infection ○ Diabetes Mellitus Type 1 ○ Diabetes Mellitus Type 2 ○ Fibromyalgia ○ Fracture Or Suspected Fracture ○ High Blood Pressure ○ Pacemaker ○ Other (Please describe below)	○ History Of Cancer (Describe below) __In Remission __Active ○ Huntington's ○ Immunosuppression ○ Lupus ○ Muscular Dystrophy ○ Obesity ○ Osteoarthritis ○ Parkinson's ○ Rheumatoid Arthritis ○ Traumatic Brain Injury ○ Infectious Disease (Describe below)

Other: _____

_____

_____

Only for patients being seen for **Low Back Pain**:
Have you experienced any of the following symptoms?

- ○ Saddle Numbness (numbness in the groin region)
- ○ Problems with urination: (circle all that apply) Incontinence Urgency Can't go
- ○ Problems with bowel: (circle all that apply) Can't control Can't go

Email: _____

(This is optional, however by providing your email it will allow us to communicate issues regarding your account, updates about our company and allow you an opportunity for online bill pay. We will not share your email with any outside agency except our contracted billing agency, LB Medical Billing, LLC)

How did you hear about us? _____