Lower Extremity Functional Index

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity.

Today, do you or would you have any difficulty at all with:

(Circle one number on each line)

Activities	Extreme Difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
a. Any of your usual work, housework or school activities.	0	1	2	3	4
b. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
c. Getting into or out of the bath.	0	1	2	3	4
d. Walking between rooms.	0	1	2	3	4
e. Putting on your shoes or socks.	0	1	2	3	4
f. Squatting.	0	1	2	3	4
g. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
h. Performing light activities around your home.	0	1	2	3	4
i. Performing heavy activities around your home.	0	1	2	3	4
j. Getting into or out of a car.	0	1	2	3	4
k. Walking 2 blocks.	0	1	2	3	4
l. Walking a mile.	0	1	2	3	4
m. Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
n. Standing for 1 hour.	0	1	2	3	4
o. Sitting for 1 hour.	0	1	2	3	4
p. Running on even ground.	0	1	2	3	4
q. Running on uneven ground.	0	1	2	3	4
r. Making sharp turns while running fast.	0	1	2	3	4
s. Hopping.	0	1	2	3	4
t. Rolling over in bed.	0	1	2	3	4
COLUMN TOTALS					

Score variation ± 6 LEFTS points
MDC & MCID = 9 LEFS points

Score _____/80

Binkley JM, Stratford PW, Lott SA, Riddle DL. The lower extremity functional scale (LEFS): scale development, measurement properties, and clinical application. Phys Ther 1999;79:371-383.

UNIVERSITY of MARYLAND
CHARLES REGIONAL
REHABILITATION

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Therapy Attendance Agreement

Welcome to Outpatient Physical Therapy at University of Maryland Charles Regional Rehabilitation. Our goal is to provide you with the best therapy services to reach your maximum potential and to improve your quality of life. We would like to inform you of our therapy attendance policy to ensure that you are getting the treatment that you need and other patients are not missing out on possible therapy times that they could have received.

Please read through and initial on the line that you have read and understand each statement:

____ CALL TO CANCEL OR RESCHEDULE. If you miss one therapy appointment without calling or cancelling at least 24 hours prior, you will be charged a $25 no show fee.

____ATTEND ALL YOUR APPOINTMENTS. If you miss three (3) consecutive therapy sessions and do not call, you will be discharged from therapy at the discretion of the therapist.

____ BE ON TIME. If you are more than 10 minutes late to a 30 minute appointment, it is up to the treating therapist if you will be seen that day.

____ If you have multiple cancellations, instances of tardiness, or missed appointments, it is up to the discretion of the primary therapist to discharge you from therapy.

All scheduling is on a first come, first served basis. We understand that both your schedule and our schedule can change and we will do our best to accommodate any changes that arise. Please inform us if you would like a copy of this form or if you have any questions about our appointment policy stated above.

Please sign that you understand and agree to the above policy:

________________________________ (Patient/Guardian) __________________ (Date & Time)

________________________________ (UM CRR Staff member) __________________ (Date & Time)

REHABILITATION SERVICES – AMBULATORY SUMMARY LIST

Please answer all questions to the best of your knowledge

Do you have any known allergies (drugs, food, pollens, latex etc): ___________________________________

Have you had any falls in the last 12 months (please circle)? **Yes** **No**

How many falls? ____________ Did any fall result in injury? **Yes** **No**

Have you had any near falls? **Yes** **No** How many in the last 12 months? _______________

How do you learn best (please circle): **Reading** **Demonstration** **Pictures** **Listening**

Do you feel safe in your home (please circle)? **Yes** **No**

Are you being threatened or hurt by someone (please circle)? **Yes** **No**

Over the past 2 weeks, how often have you been bothered by any of the following problems (please circle)?

	Not At All	**Several Days**	**More Than Half the Days**	**Nearly Every Day**
Little Interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**

What is your preferred language? ____

Which language do you want to use while you are receiving services here? ___________________________

Do you have, or have you had, any of the following?

- ☐ Aids/HIV Positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma, Bronchitis, COPD, or Emphysema
- ☐ Cancer
- ☐ Cardiac History (Angina, Congenital Heart Disorder, Heart Attack, Pace Maker, Defibrillator, Palpitations, Irregular Heartbeat, Other)
- ☐ Dementia
- ☐ Diabetes
- ☐ Dizziness or Vertigo
- ☐ Edema
- ☐ Emotional/Psychological Problems
- ☐ Epilepsy or Seizures
- ☐ Fainting Spells
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Frequent Cough
- ☐ Gout
- ☐ Headaches or Migraines
- ☐ Hearing Difficulties or Ringing in your ears
- ☐ Hepatitis A, B or C
- ☐ High/Low Blood pressure
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Memory Loss or Cognitive Problems
- ☐ Nausea/Vomiting
- ☐ Orthopedic History
- ☐ Osteoporosis
- ☐ Pain
- ☐ Pregnant or Nursing
- ☐ Recent Weight loss
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Abnormalities
- ☐ Sleeping Difficulties
- ☐ Speech Problems
- ☐ Swallowing Problems
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Surgery
- ☐ Thyroid Disease
- ☐ Traumatic Brain Injury
- ☐ Vision Problems (Galucoma, Cataracts, Macular Degeneration, etc)
- ☐ Other ____________ ________________ ________________

Comments and details regarding above history (surgeries and medication on next page): _______________

____

Has the patient OR a sick close contact had international travel with in the last 30 days? **Yes** **No**

Where was the travel to and on what dates? ______________________________________

Does the patient currently have a fever OR flu-like symptoms? **Yes** **No**

(Symptoms include headache, aches, vomiting, abdominal pain, diarrhea, chills, etc)

REHABILITATION SERVICES – AMBULATORY SUMMARY LIST

Major Surgeries	Date	Current Medication	Dosage	Frequency

(Please ask for surgery/medication form if more space is needed)

Therapist Review – Office Use only

Have you previously participated in physical/occupational/speech therapy? **Yes No**

Have you had therapy services this calendar year? **Yes No**

Were you treated for your current diagnosis or another diagnosis? **Current Different**

Have you had any recent imaging performed (please circle)?

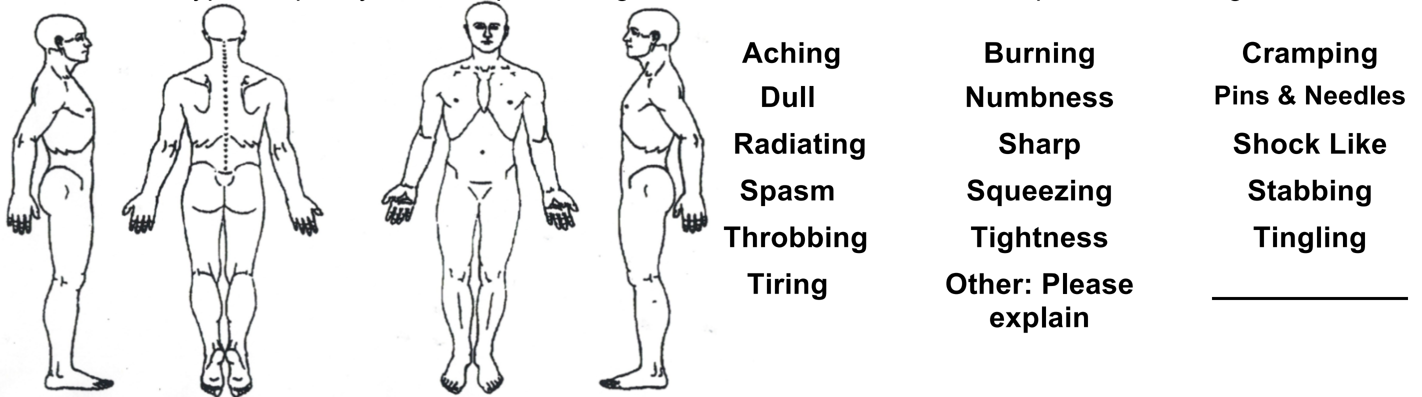
X-ray CT scan MRI EMG Modified Barium Swallow Other

Do you have any restrictions from activity from your doctor? **Yes No**

If yes, please explain: ____________________

What are your goals for therapy? ____________________

Please circle types of pain you are experiencing and draw or shade in areas of pain on the diagram:



Aching	**Burning**	**Cramping**
Dull	**Numbness**	**Pins & Needles**
Radiating	**Sharp**	**Shock Like**
Spasm	**Squeezing**	**Stabbing**
Throbbing	**Tightness**	**Tingling**
Tiring	**Other: Please explain**	____________

Advanced Directives: ☐ Durable Power of Attorney ☐ Living Will ☐ Organ Donor ☐ DNR ☐ N/A

Patients Name (Please write legibly): ____________________

Signature of Patient: ____________________ Date: __________

Signature of Caregiver (if under 18 or assisting in filling out form): ____________________

Signature of Therapist: ____________________ Date: __________

University of Maryland
Charles Regional Medical Center
LaPlata, Maryland 20646

RS-027 (0816)

PATIENT LABEL

REHABILITATION SERVICES – OUTPATIENT MEDICAL QUESTIONNAIRE