

FALLS EFFICACY SCALE

Patient _____

Date _____

Please circle the number on how confident you are doing these activities as you feel right now today

Take a bath or Shower

Very Confident: 1 2 3 4 5 6 7 8 9 10: Not Confident at All

Reach into cabinets or closets

Very Confident 1 2 3 4 5 6 7 8 9 10: Not Confident at All

Walk around the house

Very Confident: 1 2 3 4 5 6 7 8 9 10: Not Confident at All

Prepare meals not requiring heavy or hot objects

Very Confident 1 2 3 4 5 6 7 8 9 10: Not Confident at All

Get in and out of bed

Very Confident 1 2 3 4 5 6 7 8 9 10: Not Confident at All

Answer the door or telephone

Very Confident 1 2 3 4 5 6 7 8 9 10: Not Confident at All

Get in and out of a chair

Very Confident 1 2 3 4 5 6 7 8 9 10: Not Confident at All

Getting dressed and undressed

Very Confident 1 2 3 4 5 6 7 8 9 10: Not Confident at All

Personal grooming (i.e. washing you face, brushing/combing hair)

Very Confident 1 2 3 4 5 6 7 8 9 10: Not Confident at All

Getting on and off the toilet

Very Confident 1 2 3 4 5 6 7 8 9 10: Not Confident at All

Balance

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 \pm 6 LEFTS points
MDC & MCID = 9 LEFS points

Score ____/80

PAIN DISABILITY INDEX

NAME _____

DATE _____

The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. *A score of 0 means no disability at all, and a score of 10 signifies that of all of the activities in which you normally be involved have been totally disrupted or prevented by your pain.*

Family/home responsibilities: This category refers to activities of the home or family. It includes chores performed around the house and errands or favors for other family members.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Recreation: This category includes hobbies, sports, and other similar leisure time activities.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Social Activity: This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out and other social functions.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non paying jobs as well, such as housekeeper or volunteer worker.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Sexual behavior: this category refers to the frequency and quality of ones sex life;

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Self-care: This category refers to the ability to dress, bathe, groom and preform necessary daily activities.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Life Support activity: This category refers to basic life-supporting behaviors such as eating, sleeping and breathing.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability