

Foot Function Index

Name: _____ Date: _____

This questionnaire has been designed to give your therapist information as to how your foot pain has affected your ability to manage in every day life. For the following questions, we would like you to score each question on a scale from 0 (no pain) to 10 (worst pain imaginable) that best describes your foot over the past WEEK. Please read each question and place a number from 0-10 in the corresponding box.

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

1. In the morning upon taking your first step?	0 1 2 3 4 5 6 7 8 9 10
2. When walking?	0 1 2 3 4 5 6 7 8 9 10
3. When standing?	0 1 2 3 4 5 6 7 8 9 10
4. How is your pain at the end of the day?	0 1 2 3 4 5 6 7 8 9 10
5. How severe is your pain at its worst?	0 1 2 3 4 5 6 7 8 9 10

Answer all of the following questions related to your pain and activities over the past WEEK, how much difficulty did you have? No Difficulty 0 1 2 3 4 5 6 7 8 9 10 So Difficult unable to do

6. When walking in the house?	0 1 2 3 4 5 6 7 8 9 10
7. When walking outside?	0 1 2 3 4 5 6 7 8 9 10
8. When walking four blocks?	0 1 2 3 4 5 6 7 8 9 10
9. When climbing stairs?	0 1 2 3 4 5 6 7 8 9 10
10. When descending stairs?	0 1 2 3 4 5 6 7 8 9 10
11. When standing tip toe?	0 1 2 3 4 5 6 7 8 9 10
12. When getting up from a chair?	0 1 2 3 4 5 6 7 8 9 10
13. When climbing curbs?	0 1 2 3 4 5 6 7 8 9 10
14. When running or fast walking?	0 1 2 3 4 5 6 7 8 9 10

Answer all the following questions related to your pain and activities over the past WEEK. How much of the time did you: None of the time 0 1 2 3 4 5 6 7 8 9 10 All of the time

15. Use an assistive device (cane, walker, crutches, etc) indoors?	0 1 2 3 4 5 6 7 8 9 10
16. Use an assistive device (cane, walker, crutches, etc) outdoors?	0 1 2 3 4 5 6 7 8 9 10
17. Limit physical activities?	0 1 2 3 4 5 6 7 8 9 10

Score: (Total:____/170)100 = ____%