PATIENT NAME: _____ DATE:_____

FOOT FUNCTION INDEX

This questionnaire has been designed to give your therapist information as to how your foot pain has affected your ability to manage in everyday life. Please answer every question. For each of the following questions, we would like you to score each question on a scale from 0 (no pain or difficulty) to 10 (worst pain imaginable OR so difficult it required help) that best describes your foot over the past WEEK. Please read each question and place a number from 1-10 in the corresponding box.

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

Pain Subscale How severe is your foot pain:

Foot pain at its worst?	
Foot pain in the morning?	
Pain walking barefoot?	
Pain standing barefoot?	
Pain walking with shoes?	
Pain standing with shoes?	
Pain walking with orthotics?	
Pain standing with orthotics?	
Foot pain at the end of day?	

Disability Subscale How much difficulty did you have:

Difficulty walking around your house?	
Difficulty walking out side?	
Difficulty walking 4 blocks?	
Difficulty climbing stairs?	
Difficulty descending stairs?	
Difficulty standing on tip toe?	
Difficulty getting up from a chair?	
Difficulty climbing curbs?	
Difficulty walking fast?	

Activity Limitation Subscale How much of the time do you:

Stay inside all day because of your feet?	
Stay in bed because of your feet?	
Limit activities because of your feet?	
Use an assistive device (crutches, cane or walker) indoors?	
Use an assistive device (crutches, cane or walker) outdoors?	

Official Use Only: Score: _____/230 points (MCD: 7 points; No Disability "0")