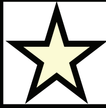

Gray Physical Therapy Center, PA

Foot Function Index

Section 1: To be completed by patient **Name:** **Age:** **Today's Date:**

Occupation: **Number of weeks of foot pain:** **(this episode)**

Section 2: To be completed by patient

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, please score each question on a scale from 0 (no pain/no difficulty/none of the time) to 10 (worst pain imaginable/so difficult activity cannot be done/all of the time) that best describes your foot pain **over the past week**. Please read each question and ***SELECT a number from 0-10 from the drop down menu***.

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?
2. When walking?
3. When standing?
4. How is your pain at the end of the day?
5. How severe is your pain at its worst?

Answer all of the following questions related to your pain / 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 Activity Couldn't Be Done**

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

Answer all of 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?
16. Use an assistive device (cane, walker, crutches, etc.) outdoors?
17. Limit physical activities?

Section 3: To be completed by physical therapist/provider **RAW SCORE:**

Calculated Score:
Raw /170 *100

Adapted from Budiman-Mak E, Conrad KJ, Roach K. The foot function index: A measure of foot pain and disability. J Clin Epidemiology. 4(6):561-70, 91.