

Patient: _____ Age: _____ DOB: ____/____/____

Occupation: _____ # hrs. on feet: _____

FOOT FUNCTION INDEX

This questionnaire has been designed to give your doctor information as to how your foot and ankle pain have affected your ability to manage in everyday 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 and ankle pain over the past WEEK. Please read each question and place a number from 0-10 on the corresponding line.

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 it is your pain at its worst? _____

Answer all of the following questions related to your pain and activities over the past WEEK, how much difficulty due to have? *Disability Scale*

No Difficulty 0 1 2 3 4 5 6 7 8 9 10 So Difficult Unable To Do

- 1. When walking in the house? _____
- 2. When walking outside? _____
- 3. When walking 4 blocks? _____
- 4. When climbing stairs? _____
- 5. When descending stairs? _____
- 6. When standing tip toe? _____
- 7. When getting up from a chair? _____
- 8. When climbing curbs? _____
- 9. When running or fast walking? _____

Answer all the following questions related to your pain and activities over the past WEEK. How much of the time did you: *Disability Scale*

None of the time 0 1 2 3 4 5 6 7 8 9 10 All of the time

- 1. Use an assistive device (cane, walker, crutches, etc.) indoors? _____
- 2. use an assistive device (cane, walker, crutches, etc.) outdoors? _____
- 3. Limited physical activities? _____

MCC USE ONLY:
(____/170 x 100 = _____ %)

Patient Signature _____ Today's Date ____/____/____