

Industrial Physical Therapy, Inc.

Foot Function Index

Name: _____ Signature: _____ Date: _____

Pain Subscale: How severe is your foot pain:

	No Pain	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable
1. Foot pain at it's worst?		1	2	3	4	5	6	7	8	9	10	
2. Foot pain in morning?		1	2	3	4	5	6	7	8	9	10	
3. Pain walking barefoot?		1	2	3	4	5	6	7	8	9	10	
4. Pain standing barefoot?		1	2	3	4	5	6	7	8	9	10	
5. Pain walking with shoes?		1	2	3	4	5	6	7	8	9	10	
6. Pain standing with shoes?		1	2	3	4	5	6	7	8	9	10	
7. Pain walking with orthotics?		1	2	3	4	5	6	7	8	9	10	
8. Pain standing with orthotics?		1	2	3	4	5	6	7	8	9	10	
9. Foot pain at end of day?		1	2	3	4	5	6	7	8	9	10	

Disability Subscale: How much difficulty did you have:

	No Difficulty	1	2	3	4	5	6	7	8	9	10	So Difficult Unable
10. Difficulty walking in house?		1	2	3	4	5	6	7	8	9	10	
11. Difficulty walking outside?		1	2	3	4	5	6	7	8	9	10	
12. Difficulty walking 4 blocks?		1	2	3	4	5	6	7	8	9	10	
13. Difficulty climbing stairs?		1	2	3	4	5	6	7	8	9	10	
14. Difficulty descending stairs?		1	2	3	4	5	6	7	8	9	10	
15. Difficulty standing tip toe?		1	2	3	4	5	6	7	8	9	10	
16. Difficulty getting up from chair?		1	2	3	4	5	6	7	8	9	10	
17. Difficulty climbing curbs?		1	2	3	4	5	6	7	8	9	10	
18. Difficulty walking fast?		1	2	3	4	5	6	7	8	9	10	

Activity Limitation Subscale: How much of the time do you:

	None of the Time	1	2	3	4	5	6	7	8	9	10	All of the Time
19. Stay inside all day because of feet?		1	2	3	4	5	6	7	8	9	10	
20. Stay in bed all day because of feet?		1	2	3	4	5	6	7	8	9	10	
21. Limit activities because of feet?		1	2	3	4	5	6	7	8	9	10	
22. Use assistive device indoors?		1	2	3	4	5	6	7	8	9	10	
23. Use assistive device outdoors?		1	2	3	4	5	6	7	8	9	10	