RIDGEWOOD PHYSICAL THERAPY
and Rehabilitation Center
104 Chestnut Street ● Ridgewood, NJ 07450

FOOT FUNCTION INDEX

SECTION 1: Name:_____D.O.B.:_____ DATE:_____

Occupation OR Student:_____ Number of Days of foot pain:_____(this episode)

SECTION 2:

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?
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 and activities **over the past WEEK**, how much difficulty did you have? **DISABILITY SCALE**

NO DIFFICULTY 0 1 2 3 4 5 6 7 8 9 10 SO DIFFICULT UNABLE TO DO

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 fast or 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

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 ONLY. SCORE:_____/170 X100=_____%

SCORE: INITIAL_____ SUBSEQUENT_____ SUBSEQUENT_____ DISCHARGE_____

NUMBER OF TREATMENT SESSIONS:_____ DIAGNOSIS/ICD-9 CODE:_____