Fig.3 FFI-R Short Form

Revised FOOT FUNCTION INDEX (FFI-R) Short Form

Subject ID: [_____]_____]_____]_____]   [Date: [___]___] / [___]___] / [___]___]___]

PAIN

PLEASE READ BEFORE ANSWERING.

- Please circle the number that indicates how bad your <u>foot</u> pain was in each of the following situations during the past week.
- For example, when asked how severe your foot pain was at its worst, if you feel "No pain," circle the number 1 and if you felt "Severe pain," circle the number 4.
- If, for some items, the question does not apply, circle the number 5.
- Please provide an answer for every item.

1. <u>DURING THE PAST WEE</u>K, HOW SEVERE WAS YOUR <u>FOOT</u> PAIN:

	No Pain	Mild pain	Moderate pain	Severe pain	
1. Before you get up in the morning?	1	2	3	4	
2. When you first stood without shoes?	1	2	3	4	
3. When you stood wearing shoes?	1	2	3	4	
4 When you walked wearing shoes?	1	2	3	4	
5. When you stood wearing custom shoe inserts? . .	1	2	3	4	5 = do not use inserts
6. When you walked wearing custom shoe inserts? .	1	2	3	4	5= do not use inserts
7. At the end of a typical day?	1	2	3	4	

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STIFFNESS

PLEASE READ BEFORE ANSWERING.

- Please circle the number that indicates how bad your <u>foot</u> stiffness was in each of the following situations during the past week.
- For example, when asked how severe your foot stiffness was at its worst, if you feel "No stiffness," circle the number 1 and if you felt "Severe stiffness," circle the number 4.
- If, for some items, the question does not apply, circle the number 5.
- Please provide an answer for every item.

1. <u>DURING THE PAST WEEK</u>, HOW SEVERE WAS YOUR <u>FOOT</u> STIFFNESS:

	No stiffness	Mild stiffness	Moderate stiffness	Severe stiffness
8. Before you get up in the morning?	1	2	3	4
9. When you stood without shoes?	1	2	3	4
10. When you walked without shoes?	1	2	3	4
11. When you stood wearing shoes?	1	2	3	4
12. When you walked wearing shoes?	1	2	3	4
13. When you walked wearing custom shoe inserts? .	1	2	3	4
14. Before you went to sleep at night?	1	2	3	4

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DIFFICULTY

PLEASE READ BEFORE ANSWERING.

- Please circle the number that indicates how much difficulty you had performing each activity because of your <u>foot</u> problems during the past week.
- For example, when asked how much difficulty your foot problems caused when walking around the house, if you had "No difficulty," circle the number 1 and if it was " Severe difficulty," circle the number 4.
- If, for some items, the question does not apply, circle the number 5.
- Please provide an answer for every item.

2. <u>DURING THE PAST WEEK</u>, HOW MUCH DIFFICULTY DID YOUR FOOT PROBLEMS CAUSE YOU:

	No difficulty	Mild difficulty	Moderate difficulty	Severe difficulty
15. Walking outside on <u>uneven</u> ground?	1	2	3	4
16. Walking four or more blocks?	1	2	3	4
17. Climbing stairs?	1	2	3	4
18. Descending stairs?	1	2	3	4
19. Standing on tip toes?	1	2	3	4
20. When you carried or lifted objects weighing more than five pounds?	1	2	3	4
21. Getting out of a chair?	1	2	3	4
22. Walking fast?	1	2	3	4

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3. (cont.) <u>DURING THE PAST WEEK</u>, HOW MUCH DIFFICULTY DID YOUR FOOT PROBLEMS CAUSE YOU:

	No difficulty	Mild difficulty	Moderate difficulty	Severe difficulty
23. Running?	1	2	3	4
24. Keeping your balance?	1	2	3	4
25. Walking with assistive devices?	1	2	3	4

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ACTIVITY LIMITATION

PLEASE READ BEFORE ANSWERING.

- Please circle the number that indicates how often you performed each of these activities in the past week because of your <u>feet</u>.
- For example, when asked how often you used a cane indoors because of foot problems, if you used one "None of the time," circle the number 1 and if you used one "All of the time," circle the number 4.
- If, for some items, the question does not apply, circle the number 5.
- Please provide an answer for every item.

4. <u>DURING THE PAST WEEK</u>, HOW MUCH OF THE TIME DID YOU:

	None of the time	Some of the time	Most of the time	All of the time	
26. Stay indoors most of the day because of foot problems?	1	2	3	4	
27. Limit your <u>outdoor</u> activities because of foot problems?	1	2	3	4	5= No outdoor activities
28. Limit your leisure/sport activities because of foot problems?	1	2	3	4	5 = Do not play sports

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SOCIAL ISSUES

PLEASE READ BEFORE ANSWERING.

- Please circle the number that indicates how often you experienced the following feelings in the past week because of your <u>feet</u>.
- For example, when asked how often you felt a fear of falling because of foot problems, if you felt fear "None of the time," circle the number 1 and if you felt fear "All of the time," circle the number 4.
- If, for some items, the question does not apply, circle the number 5.
- Please provide an answer for every item.

5. <u>DURING THE PAST WEEK</u>, HOW MUCH OF THE TIME DID YOU EXPERIENCE:

	None of the time	Some the time	Most the time	All of the time	
29. Embarrassment due to footwear?	1	2	3	4	
30. Feeling awful because of foot problem?	1	2	3	4	
31. Limit social activities due to foot problems? . .	1	2	3	4	
32. Difficulty participating in social activities due to footwear?	1	2	3	4	_____
33. Burden of taking medication to control foot pain?	1	2	3	4	_____
34. Concern about limited work around the house?.	1	2	3	4	_____

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SUBJECT COMMENTS:

Please comment about:

1. Were the <u>directions</u> clear?

2. Were any of the <u>questions</u> difficult to understand?

3. Were any of the <u>questions</u> unclear? If yes, which ones and why?

4. Did any of the <u>questions</u> make you uncomfortable? If yes, which ones and why?

5. Are there any issues about your feet that <u>were not asked</u> or that you would add to the questionnaire? If yes, which issues?

6. Did you have any problems with this <u>questionnaire</u> that you would like to mention? If yes, which problems?

Thank you for participating in this study.

Pain score: _____
Stiffness score: _____
Difficulty score: _____
Activity score: _____

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Social score: _____
        Cumulative score: _____