Supplemental Material B. Foot Function Index

DATE: _____

NAME _____ SURNAME _____

This questionnaire has been designed to give your therapist information as to how your foot pain has affected your ability to manage in everyday life. Please answer every question. For each of the following questions, we would like you to score each question on a scale from 0 (no pain or difficulty) to 10 (worst pain imaginable or so difficult it required help) that best describes your foot over the past WEEK.

Pain Subscale: How severe is your foot pain:

1. **Foot pain at its worst?** No pain _____ Worst Pain Imaginable
2. **Foot pain in morning?** No pain _____ Worst Pain Imaginable
3. **Pain walking barefoot?** No pain _____ Worst Pain Imaginable
4. **Pain standing barefoot?** No pain _____ Worst Pain Imaginable
5. **Pain walking with shoes?** No pain _____ Worst Pain Imaginable
6. **Pain standing with shoes?** No pain _____ Worst Pain Imaginable
7. **Pain walking with orthotics?** No pain _____ Worst Pain Imaginable
8. **Pain standing with orthotics?** No pain _____ Worst Pain Imaginable
9. **Foot pain at end of day?** No pain _____ Worst Pain Imaginable

Disability Subscale: How much difficulty did you have:

10. **Difficulty walking in house?** No difficulty _____ So difficult unable
11. **Difficulty walking outside?** No difficulty _____ So difficult unable
12. **Difficulty walking 4 blocks?** No difficulty _____ So difficult unable
13. **Difficulty climbing stairs?** No difficulty _____ So difficult unable
14. **Difficulty descending stairs?** No difficulty _____ So difficult unable
15. **Difficulty standing tip toe?** No difficulty _____ So difficult unable
16. **Difficulty getting up from chair?** No difficulty _____ So difficult unable
17. **Difficulty climbing curbs?** No difficulty _____ So difficult unable
18. **Difficulty walking fast?** No difficulty _____ So difficult unable

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

19. **Stay inside all day because of feet?** None of the time _____ All of the time
20. **Stay in bed because of feet?** None of the time _____ All of the time
21. **Limit activities because of feet?** None of the time _____ All of the time
22. **Use assistive device indoors?** None of the time _____ All of the time
23. **Use assistive device outdoors?** None of the time _____ All of the time

Score: ____/230 points x 100= ___%