

FOOT FUNCTION INDEX (FFI)

NAME: _____

DATE: _____

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, please circle a number from 0 to 10 for each question that best describes your foot **over the past week**.

HOW SEVERE IS YOUR FOOT PAIN:

0 = no pain

10 = worst pain imaginable

Foot pain at its worst?	0	1	2	3	4	5	6	7	8	9	10
Foot pain in the morning?	0	1	2	3	4	5	6	7	8	9	10
Pain when walking?	0	1	2	3	4	5	6	7	8	9	10
Pain when standing?	0	1	2	3	4	5	6	7	8	9	10
Foot pain at end of day?	0	1	2	3	4	5	6	7	8	9	10

HOW MUCH DIFFICULTY DO YOU HAVE:

0 = no difficulty

10 = so difficult it requires help

When walking in the house?	0	1	2	3	4	5	6	7	8	9	10
When walking outside?	0	1	2	3	4	5	6	7	8	9	10
When walking 4 blocks?	0	1	2	3	4	5	6	7	8	9	10
When climbing stairs?	0	1	2	3	4	5	6	7	8	9	10
When descending stairs?	0	1	2	3	4	5	6	7	8	9	10
When standing tip toe?	0	1	2	3	4	5	6	7	8	9	10
When getting up from a chair?	0	1	2	3	4	5	6	7	8	9	10
When climbing curbs?	0	1	2	3	4	5	6	7	8	9	10
When running or walking fast?	0	1	2	3	4	5	6	7	8	9	10

HOW MUCH OF THE TIME DO YOU:

0 = none of the time

10 = all of the time

Limit activities because of feet?	0	1	2	3	4	5	6	7	8	9	10
Use assistive device (cane, walker, etc) indoors?	0	1	2	3	4	5	6	7	8	9	10
Use assistive device (cane, walker, etc) outdoors?	0	1	2	3	4	5	6	7	8	9	10

Total score: _____ ÷ 170 x 100% = _____%

G-Code: FFI: 0 = CH 1-19 = CI 20-39 = CJ 40-59 = CK 60-79 = CL 80-99 = CM 100 = CN
