

Name: _____

Date: _____

Pain , Activity & Patient Satisfaction Scales (fill in the circle like this)

Pain: Are you having any pain in your foot?

none	0	1	2	3	4	5	6	7	8	9	10	worst
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Activity: Are you limited in your daily activities?

Not limited at all	0	1	2	3	4	5	6	7	8	9	10	severely limited
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Satisfaction: Are you satisfied with your treatment or operation to date?

Not satisfied at all	0	1	2	3	4	5	6	7	8	9	10	completely satisfied
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Foot Function Index (fill in the circle like this)

PAIN SUBSCALE: How severe is your foot pain when you walk barefoot?

no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain imaginable
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

DISABILITY SUBSCALE: How much difficulty do you have climbing stairs?

no difficulty	0	1	2	3	4	5	6	7	8	9	10	very difficult, unable
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

ACTIVITY LIMITATIONS SUBSCALE: How much of the time do you stay indoors during the day because you have foot problems?

none of the time	0	1	2	3	4	5	6	7	8	9	10	all of the time
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	