

The answers you provide will help your health care professional to understand how to care for your presenting symptoms. The questionnaire is simple to complete and there are no right or wrong answers. The questionnaire takes less than 10 minutes to complete.

Thank you for taking the time to fill out this important questionnaire.

# Foot Health Status Questionnaire

Please complete the following details.

First Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Health Care Professional: \_\_\_\_\_

Survey Number: ☐ Initial ☐ Subsequent

## INSTRUCTIONS

This questionnaire asks for your views about your foot health.  
All you need to do is circle your answer to each question.  
If you are unsure about how to answer a question, please give the best answer you can.  
The following questions are about the foot pain you have had during the past week.

1. What level of foot pain have you had during the past week ?

1) None      2) Very Mild      3) Mild      4) Moderate      5) Severe

DURING THE LAST WEEK... (Tick mark in each box below)

	Never	Occasionally	Fairly Many Times	Very Often	Always
2. How often have you had foot pain?					
3. How often did your feet ache?					
4. How often did you get sharp pains in your feet?					

These questions are about how much your feet interfere with activities you might do during a typical day.

DURING THE LAST WEEK... (Tick mark in each box below)

	Not at all	Slightly	Moderately	Quite a bit	Extremely
5. Have your feet caused you to have difficulties in your work or activities?					
6. Were you limited in the kind of work you could do because of your feet?					
7. How much does your foot health limit you walking?					
8. How much does your foot health limit you climbing stairs?					



9. How would you rate your overall foot health?

1) Excellent      2) Very Good      3) Good      4) Fair      5) Poor

10. In general, what condition would you say your feet are in ? (circle number)

1) Excellent      2) Very Good      3) Good      4) Fair      5) Poor

11. In general, how would you rate your health : (circle number)

1) Very Good      2) Fair      3) Poor

**12. The following questions ask about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?** (Tick mark in each box below)

ACTIVITIES	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
a. Vigorous activities, such as running, lifting heavy objects, or (if you wanted to) your ability to participate in strenuous sports			
b. Moderate activities, such as cleaning the house, lifting a chair, playing golf or swimming			
c. Lifting or carrying bags of shopping			
d. Climbing a steep hill			
e. Climbing one flight of stairs			
f. Getting up from a sitting position			
g. Walking more than a kilometre			
h. Walking one hundred meters			
i. Showering or dressing yourself			

**13. The following questions ask about activities during the past month.**

These questions are about how you “feel” and how things have been with you during the past month. For each question, please give the one answer that comes closest to the way you have been “feeling”. How much of the time during the last four weeks:

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Did you feel tired?					
b. Did you have a lot of energy?					
c. Did you feel worn out?					
d. Did you feel full of life?					

**14. How TRUE or FALSE is each of the following statements for you?**

	True or mostly true	Don't know	False or mostly false
a. I seem to get sick a little easier than other people			
b. I am as healthy as anybody I know			
c. I expect my health to get worse			
d. My health is excellent			

