

# FAOS FOOT & ANKLE SURVEY

Today's date: \_\_\_\_\_ Date of birth: \_\_\_\_\_

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

**INSTRUCTIONS:** This survey asks for your view about your foot/ankle. This information will help us keep track of how you feel about your foot/ankle and how well you are able to do your usual activities.

Answer every question by ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

## Symptoms

These questions should be answered thinking of your foot/ankle symptoms during the **last week**.

S1. Do you have swelling in your foot/ankle?

Never  Rarely  Sometimes  Often  Always

S2. Do you feel grinding, hear clicking or any other type of noise when your foot/ankle moves?

Never  Rarely  Sometimes  Often  Always

S3. Does your foot/ankle catch or hang up when moving?

Never  Rarely  Sometimes  Often  Always

S4. Can you straighten your foot/ankle fully?

Always  Often  Sometimes  Rarely  Never

S5. Can you bend your foot/ankle fully?

Always  Often  Sometimes  Rarely  Never

## Stiffness

The following questions concern the amount of joint stiffness you have experienced during the **last week** in your foot/ankle. Stiffness is a sensation of restriction or slowness in the ease with which you move your joints.

S6. How severe is your foot/ankle stiffness after first wakening in the morning?

None  Mild  Moderate  Severe  Extreme

S7. How severe is your foot/ankle stiffness after sitting, lying or resting **later in the day**?

None  Mild  Moderate  Severe  Extreme

**Pain**

P1. How often do you experience foot/ankle pain?

Never	Monthly	Weekly	Daily	Always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What amount of foot/ankle pain have you experienced the **last week** during the following activities?

P2. Twisting/pivoting on your foot/ankle

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

P3. Straightening foot/ankle fully

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

P4. Bending foot/ankle fully

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

P5. Walking on flat surface

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

P6. Going up or down stairs

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

P7. At night while in bed

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

P8. Sitting or lying

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

P9. Standing upright

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Function, daily living**

The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your foot/ankle.

A1. Descending stairs

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A2. Ascending stairs

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your foot/ankle.

## A3. Rising from sitting

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## A4. Standing

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## A5. Bending to floor/pick up an object

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## A6. Walking on flat surface

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## A7. Getting in/out of car

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## A8. Going shopping

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## A9. Putting on socks/stockings

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## A10. Rising from bed

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## A11. Taking off socks/stockings

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## A12. Lying in bed (turning over, maintaining foot/ankle position)

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## A13. Getting in/out of bath

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## A14. Sitting

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## A15. Getting on/off toilet

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your foot/ankle.

A16. Heavy domestic duties (moving heavy boxes, scrubbing floors, etc)

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A17. Light domestic duties (cooking, dusting, etc)

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Function, sports and recreational activities

The following questions concern your physical function when being active on a higher level. The questions should be answered thinking of what degree of difficulty you have experienced during the **last week** due to your foot/ankle.

SP1. Squatting

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SP2. Running

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SP3. Jumping

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SP4. Twisting/pivoting on your injured foot/ankle

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SP5. Kneeling

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Quality of Life

Q1. How often are you aware of your foot/ankle problem?

Never	Monthly	Weekly	Daily	Constantly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q2. Have you modified your life style to avoid potentially damaging activities to your foot/ankle?

Not at all	Mildly	Moderately	Severely	Totally
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q3. How much are you troubled with lack of confidence in your foot/ankle?

Not at all	Mildly	Moderately	Severely	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q4. In general, how much difficulty do you have with your foot/ankle?

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Thank you very much for completing all the questions in this questionnaire.**