

## Functional Limitation and Activity Index Sheet

The rating scales below are designed to measure the degree to which aspects of your life are disrupted by your foot and/or ankle problem. In other words, we would like to know how much your foot and/or ankle problem is preventing you from doing the activities mentioned below, or participating in the activities as well as you normally would.

Respond to each category below indicating the overall impact of your foot and/or ankle problem in your life.

For each of the categories, please circle the number that describes the level of limitation you typically experience. Circling 0 indicates no impact from your foot and/or ankle problem at all, while a score of 10 indicates total disruption of that activity due to your foot and/or ankle problem.

Your healthcare professional may ask you to complete this sheet regularly, even daily, during your treatment to gauge your improvement and to assess the achievement of the functional goals that have been set.

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**Family/Home Responsibilities:** This category refers to activities of the family or home. It includes chores or duties performed around the house (e.g. yard work, cleaning) and errands or favors for other family members (e.g. driving the children or grandchildren to school).

**No Limitation**    0    1    2    3    4    5    6    7    8    9    10    **Worst Limitation**

**Recreation:** This includes hobbies, sports, and other leisure time activities.

**No Limitation**    0    1    2    3    4    5    6    7    8    9    10    **Worst Limitation**

**Social Activity:** This refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, concerts, events, dining out, and other social activities.

**No Limitation**    0    1    2    3    4    5    6    7    8    9    10    **Worst Limitation**

**Occupation:** This refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.

**No Limitation**    0    1    2    3    4    5    6    7    8    9    10    **Worst Limitation**

**Walking Surfaces:** Please indicate any limitations you have ambulating on the following surfaces:

Uneven Terrain:    **No Limitation**    0    1    2    3    4    5    6    7    8    9    10    **Worst Limitation**

Stairs:    **No Limitation**    0    1    2    3    4    5    6    7    8    9    10    **Worst Limitation**

Inclines:    **No Limitation**    0    1    2    3    4    5    6    7    8    9    10    **Worst Limitation**

**Walking Distance:** Please answer the following questions about your current ability to walk.

Continuous walking time in minutes before symptoms present: \_\_\_\_\_

Distance walked before symptoms present: \_\_\_\_\_

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**Patient Name**

**Date**

Pre-Treatment

Daily Log

Weekly Log

Monthly Log

(Please Circle)