



Foot & Ankle Survey

Date:

First Name:

Surname:

Physician: Dr Jeff Ling Dr David Lunz

Instructions: This survey asks for your views about your health. This information will help us keep track of how your symptoms interfere with your functioning. Please answer every question by filling in the appropriate circle, only one selection 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.

- | | <u>Never</u> | <u>Rarely</u> | <u>Sometimes</u> | <u>Often</u> | <u>Always</u> |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| S1. Do you have swelling in your foot/ankle? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| S2. Do you feel grinding? Hear clicking or any type of noise when your foot/ankle moves? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| S3. Does your foot/ankle catch or hang when moving? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

- | | <u>Always</u> | <u>Often</u> | <u>Sometimes</u> | <u>Rarely</u> | <u>Never</u> |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| S4. Can you straighten your foot/ankle fully? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| S5. Can you bend your foot/ankle fully? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

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 which you move your joints.

- | | <u>None</u> | <u>Mild</u> | <u>Moderate</u> | <u>Severe</u> | <u>Extreme</u> |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| S6. How severe is your foot/ankle stiffness after first wakening in the morning? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| S7. How severe is your foot/ankle stiffness after sitting, laying or resting later in the day? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |



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Pain

Never Monthly Weekly Daily Always

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

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

None Mild Moderate Severe Extreme

P2. Twisting/pivoting on your foot/ankle

P3. Straightening foot/ankle fully

P4. Bending foot/ankle surface

P5. Going up or down stairs

P6. At night while in bed

P7. Sitting or laying

P8. Standing upright

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.

None Mild Moderate Severe Extreme

A1. Descending stairs

A2. Ascending stairs

A3. Rising from sitting

A4. Standing

A5. Bending to floor/pick up an object

A6. Walking on a flat surface

A7. Getting in/out of car

A8. Going shopping

A9. Putting on socks/stockings

A10. Rising from bed



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	<u>None</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>	<u>Extreme</u>
A11. Taking off socks/stockings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A12. Lying in bed (turning over, maintaining knee position)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A13. Getting in/out of the bath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A14. Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A15. Getting on/off the toilet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A16. Heavy domestic duties (moving heavy boxes, scrubbing floors etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A17. Light domestic duties (cooking, dusting, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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.

	<u>None</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>	<u>Extreme</u>
SP1. Squatting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SP2. Running	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SP3. Jumping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SP4. Twisting.pivoting on your injured foot/ankle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SP5. Kneeling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Quality of Life

	<u>Never</u>	<u>Monthly</u>	<u>Weekly</u>	<u>Daily</u>	<u>Always</u>
Q1. How often are you aware of your foot/ankle problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<u>Not at all</u>	<u>Mildly</u>	<u>Moderately</u>	<u>Severely</u>	<u>Extreme</u>
Q2. Have you modified your lifestyle to avoid potential damaging activities to your foot/ankle?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Q3. How much are you troubled with lack of confidence in your foot/ankle?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Q4. In general, how much difficulty do you have with your foot/ankle?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Foot & Ankle Survey

General Health Survey

Date:

First Name:

Surname:

Physician: Dr Jeff Ling

Dr David Lunz

Instructions: This survey asks for your views about your health. This information will help us keep track of how you feel and how well you are able to do your usual activities. Please answer these questions taking into account all medical conditions you may have, including your foot & ankle problem. Please fill in **ONLY ONE** response that best describes your answer.

1. In general, would you say that your health is:	Excellent	Verv Good	Good	Fair	Poor						
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>						
2. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?	Limited a lot	Limited a little	Not limited at all								
a. First, moderate activities such as moving a table, pushing a vacuum cleaner, bowling or playing golf.	<input type="radio"/>	<input type="radio"/>									
b. Climbing several flights of stairs.	<input type="radio"/>	<input type="radio"/>									
3. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?	All of the time	Most of the time	Some of the time	A little of the time	None of the time						
a. Accomplished less than you would like	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>						
b. Were limited in the kind of work or other activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>						
4. During the past 4 weeks, how much time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?	All of the time	Most of the time	Some of the time	A little of the time	None of the time						
a. Accomplished less than you would like	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>						
b. Did work or other activities less carefully than usual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>						
5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework) ?	Not at all	A little bit	Moderately	Quite a bit	Extremely						
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>						
6. These questions are about how you feel and how things have been with you during the past 4 weeks. 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 past 4 weeks...	All of the time	Most of the time	Some of the time	A little of the time	None of the time						
a. Have you felt calm and peaceful?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>						
b. Did you have a lot of energy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>						
c. Have you felt down hearted and depressed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>						
7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?	All of the time	Most of the time	Some of the time	A little of the time	None of the time						
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>						
On a scale of 0-10, 10 being the worst pain and 0 being no pain, how would you rate your pain?	0	1	2	3	4	5	6	7	8	9	10
	<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 & Ankle Survey

Activity Rating Scale

Date:

First Name:

Surname:

Physician: Dr Jeff Ling Dr David Lunz

Please indicate how often you performed each activity in your healthiest and most active state, during the past year.

Instructions: This survey asks for your level of activity. This information will help us keep track of how your symptoms interfere with your functioning.

Please answer every question by filling in the appropriate circle, only one selection for each question. If you are unsure about how to answer a question, please give the best answer you can

	<u>Less than one time in a month</u>	<u>One time in a month</u>	<u>One time in a week</u>	<u>2 or 3 times in a week</u>	<u>4 or more times in a week</u>
A1. <u>Running:</u>					
Running while playing a sport or jogging	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A2. <u>Cutting:</u>					
Changing directions while running	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A3. <u>Decelerating:</u>					
Coming to a quick stop while running	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A4. <u>Pivoting:</u>					
Turning your body with your foot planted For example: skiing, skating, kicking, throwing, hitting a ball (golf, squash, tennis), etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>