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Foot and Ankle Ability Measure (FAAM)

Please answer **every question** by filling in the one response that most closely describes your condition within the past week.

If the activity in question is limited by something other than your foot or ankle, mark not applicable (N/A).

	No difficulty	Slight difficulty	Moderate difficulty	Extreme difficulty	Unable to do	N/A
Standing	<input type="checkbox"/>					
Walking on even ground	<input type="checkbox"/>					
Walking on even ground without shoes	<input type="checkbox"/>					
Walking up hills	<input type="checkbox"/>					
Walking down hills	<input type="checkbox"/>					
Going up stairs	<input type="checkbox"/>					
Going down stairs	<input type="checkbox"/>					
Walking on uneven ground	<input type="checkbox"/>					
Stepping up and down curbs	<input type="checkbox"/>					
Squatting	<input type="checkbox"/>					
Coming up on your toes	<input type="checkbox"/>					
Walking initially	<input type="checkbox"/>					
Walking 5 minutes or less	<input type="checkbox"/>					
Walking approximately 10 minutes	<input type="checkbox"/>					
Walking 15 minutes or greater	<input type="checkbox"/>					

Continued on the next page...

For Office Use Only:

Patient Information:

(PUT LABEL HERE)

Date / /

MRN



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Because of your **foot and ankle** how much difficulty do you have with:

	No difficulty	Slight difficulty	Moderate difficulty	Extreme difficulty	Unable to do	N/A
Home Responsibilities	<input type="checkbox"/>					
Activities of daily living	<input type="checkbox"/>					
Personal care	<input type="checkbox"/>					
Light to moderate work (standing, walking)	<input type="checkbox"/>					
Heavy work (pushing/pulling, climbing, carrying)	<input type="checkbox"/>					
Recreational activities	<input type="checkbox"/>					

How would you rate your current level of function during your usual activities of daily living from 0 to 100 with 100 being your level of function prior to your foot or ankle problem and 0 being the inability to perform any of your usual daily activities?

.0%

FAAM Sports Scale

Because of your **foot and ankle** how much difficulty do you have with:

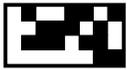
	No difficulty	Slight difficulty	Moderate difficulty	Extreme difficulty	Unable to do	N/A
Running	<input type="checkbox"/>					
Jumping	<input type="checkbox"/>					
Landing	<input type="checkbox"/>					
Starting and stopping quickly	<input type="checkbox"/>					
Cutting/lateral movements	<input type="checkbox"/>					
Low impact activities	<input type="checkbox"/>					
Ability to perform activity with your normal technique	<input type="checkbox"/>					
Ability to participate in your desired sport as long as you would like	<input type="checkbox"/>					

How would you rate your current level of function during your sports related activities from 0 to 100 with 100 being your level of function prior to your foot or ankle problem and 0 being the inability to perform any of your usual daily activities?

.0%

Overall, how would you rate your current level of function?

Normal Nearly Normal Abnormal Severely abnormal



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SF-36 Health Survey

Instructions:

Please answer every question. Some questions may look like others, but each one is different. Please take the time and answer each question carefully by filling in the box that best represents your response.

In general, would you say your health is:

- Excellent Very good Good Fair Poor

Compared to one year ago, how would you rate your health in general now?

- Much better now than a year ago
 Somewhat better now than a year ago
 About the same as one year ago
 Somewhat worse now than one year ago
 Much worse now than one year ago

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?

	No, not limited at all	Yes, limited a little	Yes, limited a lot
Vigorous activities, such as running, lifting heavy objects, or participating in strenuous sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting or carrying groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing one flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending, kneeling, or stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking more than one kilometer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking half a kilometer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking 100 meters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
Cut down the amount of time you spent on work or other activities?	<input type="checkbox"/>	<input type="checkbox"/>
Accomplished less than you would like?	<input type="checkbox"/>	<input type="checkbox"/>
Were limited in the kind of work or activities	<input type="checkbox"/>	<input type="checkbox"/>
Had difficulty performing the work or other activities (for example, it took extra time)	<input type="checkbox"/>	<input type="checkbox"/>



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During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your emotional problems (such as feeling depressed or anxious)?

	Yes	No
Cut down the amount of time you spent on work or other activities?	<input type="checkbox"/>	<input type="checkbox"/>
Accomplished less than you would like?	<input type="checkbox"/>	<input type="checkbox"/>
Didn't do work or other activities as carefully as usual	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks...

	Not at all	Slightly	Moderately	Quite a bit	Extremely
To what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?	<input type="checkbox"/>				
How much bodily pain have you had?	<input type="checkbox"/>				
How much did the pain interfere with your normal work (including both work outside the home and housework)?	<input type="checkbox"/>				

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	A good bit of the time	Some of the time	A little of the time	None of the time
Did you feel full of pep?	<input type="checkbox"/>					
Have you been a very nervous person?	<input type="checkbox"/>					
Have you felt so down in the dumps nothing could cheer you up?	<input type="checkbox"/>					
Have you felt calm and peaceful?	<input type="checkbox"/>					
Do you have a lot of energy?	<input type="checkbox"/>					
Have you felt downhearted and blue?	<input type="checkbox"/>					
Did you feel worn out?	<input type="checkbox"/>					
Have you been a happy person?	<input type="checkbox"/>					
Did you feel tired?	<input type="checkbox"/>					



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During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (live 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

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

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
I seem to get sick a little easier than other people	<input type="checkbox"/>				
I am as healthy as anybody I know	<input type="checkbox"/>				
I expect my health to get worse	<input type="checkbox"/>				
My health is excellent	<input type="checkbox"/>				

Thank you for completing this questionnaire!