AOFAS SCORE

*MARK THE DESCRIPTION THAT MOST CLOSELY RELATES TO YOUR CURRENT CONDITION

PAIN (MARK ONE)

□ NONE □ MILD, OCCASIONAL □ MODERATE, DAILY □ SEVERE, ALMOST ALWAYS PRESENT

FUNCTION (MARK ONE) (MEANING ACTIVITY LIMITATIONS, SUPPORT REQUIREMENT)

□ NO LIMITATIONS, NO SUPPORT

□ NO LIMITATION OF DAILY ACTIVITIES, LIMITATION OF RECREATIONAL ACTIVITIES, NO SUPPORT

□ LIMITED DAILY RECREATIONAL ACTIVITIES: CANE

□ SEVERE LIMITATION OF DAILY AND RECREATIONAL ACTIVITIES: WALKER, CRUTCHES, WHEELCHAIR, BRACE

MAXIMUM WALKING DISTANCE IN BLOCKS (MARK ONE)

□ GREATER THAN 6 □ 4-6 □ 1-3 □ LESS THAN 1

WALKING SURFACES (MARK ONE)

□ NO DIFFICULTY ON ANY SURFACE

□ SOME DIFFICULTY ON UNEVEN TERRAIN, STAIRS, INCLINES, LADDERS

□ SEVERE DIFFICULTY ON UNEVEN TERRAIN, STAIRS, INCLINES, LADDERS

FOR OFFICE USE ONLY BELOW THIS LINE

GAIT ABNORMALITY

NONE, SLIGHT	8
OBVIOUS	4
MARKED	0

SAGITTAL MOTION (FLEXION PLUS EXTENSION)

NORMAL OR MILD RESTRICTION (30° OR MORE)	8
MODERATE RESTRICTION (15° - 29°)	4
SEVERE RESTRICTION (LESS THAN 15°)	0

HINDFOOT MOTION

NORMAL OR MILD RESTRICTION (75% - 100%)	6
MODERATE RESTRICTION (25% - 74%)	3
SEVERE RESTRICTION (LESS THAN 25% NORMAL)	0

ANKLE-HINDFOOT STABILITY (ANTEROPOSTERIOR VARUS-VALGUS)

STABLE	8
DEFINITLEY UNSTABLE	0

ALIGNMENT

GOOD, PLANTIGRADE FOOT, MIDFOOT WELL ALIGNED	15
FAIR, PLANTIGRADE FOOT, SOME DEGREE OF MIDFOOT ALIGNMENT OBSERVED, NO SYMPTOMS	8
POOR, NONPLANTIGRADE FOOT, SEVERE MALALIGNMENT, SYMPTOMS	0

FOOT FUNCTION INDEX

NUMBER OF DAYS OF FOOT PAIN: _____ (THIS EPISODE)

THESE QUESTIONS ARE TO DETERMINE HOW YOUR FOOT PAIN HAS AFFECTED YOUR ABILITY TO MANAGE IN EVERYDAY LIFE. SCORE THE FOLLOWING QUESTIONS ON A SCALE FROM 0 (NO PAIN) TO 10 (WORST PAIN IMAGINABLE) THAT BEST DESCRIBE YOUR FOOT *OVER THE PAST WEEK.* PLACE A NUMBER FROM 0-10 IN THE SPACE PROVIDED NEXT TO EACH QUESTION.

NO PAIN-0 1 2 3 4 5 6 7 8 9 10-WORST PAIN IMAGINABLE

1. In the morning upon taking your first step? _____ (0-10)
2. When walking? _____ (0-10)
3. When standing? _____ (0-10)
4. How is your pain at the end of the day? _____ (0-10)
5. How severe is your pain at its worst? _____ (0-10)

ANSWER THE FOLLOWING QUESTIONS RELATED TO YOUR PAIN AND ACTIVITIES *OVER THE PAST WEEK.*
HOW MUCH DIFFICULTY DID YOU HAVE?

NO DIFFICULTY-0 1 2 3 4 5 6 7 8 9 10-SO DIFFICULT UNABLE TO DO

6. When walking in the house? _____ (0-10)
7. When walking outside? _____ (0-10)
8. When walking 4 blocks? _____ (0-10)
9. When climbing stairs? _____ (0-10)
10. When descending stairs? _____ (0-10)
11. When standing tip toe? _____ (0-10)
12. When getting up from a chair? _____ (0-10)
13. When climbing curbs? _____ (0-10)
14. When running or fast walking? _____ (0-10)

ANSWER THE FOLLOWING QUESTIONS RELATED TO YOUR PAIN AND ACTIVITIES *OVER THE PAST WEEK.*
HOW MUCH OF THE TIME DID YOU:

NONE OF THE TIME-0 1 2 3 4 5 6 7 8 9 10-ALL OF THE TIME

15. Use an assistive device (cane, walker, crutches, etc) indoors? _____ (0-10)
16. Use an assistive device (cane, walker, crutches, etc) outdoors? _____ (0-10)
17. Limit physical activities? _____ (0-10)

_____FOR OFFICE USE ONLY BELOW THIS LINE_____

SCORE: _____/ 170 X 100 = _____ %

SCORE: INITIAL_____ SUBSEQUENT_____ SUBSEQUENT_____ DISCHARGE_____

NUMBER OF TREATMENT SESSIONS: _____ DIAGNOSIS/ICD-10 CODE: _____