

## Alta Physical & Complementary Therapies Leg/Knee/Ankle/ Foot Index

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

This questionnaire will give your physical therapist information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If 2 or more statements one section apply, please mark the one statement that most closely describes your problem. \*Note: ROM = range of motion

### Activities

1. List activities you have difficulty with i.e. usual work, school, or housework.

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2. Your usual hobbies, recreational or sporting activities – please list any you have difficulty with.

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3. Getting into or out of bed.
4. Walking between rooms.
5. Putting on your shoes or socks.
6. Squatting.
7. Lifting an object, like a bag of groceries from the floor.
8. Getting into or out of a car.
9. Walking <10 minutes.
10. Walking >30 minutes.
11. Walking >60 minutes.
12. Going up or down 10 stairs (about 1 flight of stairs).
13. Standing <10 minutes.
14. Sitting >30 minutes.
15. Sitting >60 minutes.
16. Running on even ground.
17. Running on uneven ground.
18. Making sharp turns while running fast.
19. Hopping.
20. Rolling over in bed.
21. Driving.
22. Sleeping through the night.
23. Lying on right side \_\_\_\_\_ left side \_\_\_\_\_ back \_\_\_\_\_.

### **Functional Scale:**

Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>

