1. Plantar fasciitis is the most common cause of plantar heel pain and can be managed effectively in the outpatient setting.

2. Plantar fasciitis is an inflammatory process involving the plantar aponeurosis.

3. Patients with plantar fasciitis often present with medial plantar heel pain that is worse during the first few steps in the morning.

4. Risk factors for plantar fasciitis include obesity, tight calf muscles, prolonged standing, and sudden increase in running volume and/or intensity.

5. Plantar fasciitis can be diagnosed when heel spurs are seen on lateral radiographs of the foot.

6. Ultrasonography results are deemed abnormal when the thickness of the plantar fascia exceeds 4.0 mm.

7. The mainstay of treatment for plantar fasciitis is largely surgical.

8. The plantar fascia-specific stretch has been shown to be efficacious in treating plantar fasciitis.

9. The isolated Achilles tendon stretch is more effective than the plantar fascia-specific stretch in relieving the pain of plantar fasciitis.

10. Plantar fascia-specific stretches should not be done more than three times a day.

11. The use of dorsiflexion night splints can help to improve plantar fascia pain in as little as four weeks.

12. Orthotics can help to alleviate plantar fasciitis but must be custom-fitted, as prefabricated ones are not effective.

13. Nonsteroidal anti-inflammatory drugs have not been shown to be effective in the treatment of plantar fasciitis.

14. A localised injection of steroids can be effective for short-term relief of pain.

15. Multiple localised injections of steroids can be done for the patient who has recurrence of pain after previous injections, as there are no known adverse effects.

16. Ultrasonography-guided focal extracorporeal shockwave therapy (fESWT) can be used to treat recalcitrant plantar fasciitis.

17. A single session of ultrasonography-guided fESWT is enough to treat recalcitrant plantar fasciitis.

18. Activity modification to reduce repetitive impact should be advised.

19. All sporting activities should cease until the patient is completely asymptomatic.

20. Patients should be allowed to gradually increase their amount of repetitive impact activities 4–6 weeks after they become asymptomatic.