Surname: _____ **First name**: _____ **Patient number**: _____

Does the parent or guardian consent to being included: ☐No ☐Yes

Does the parent or guardian consent to photographs of the patient being used for evaluation/marketing purposes: ☐No ☐Yes

General Information

Sex: ☐ Male ☐ Female Date of birth (dd/mm/yyyy): _____/_____/_____

Address 1:_____

Village:_____ State/Province_____

Parent/Guardian Information

Surname: _____First name: _____ Middle name: _____

Relationship to patient: ☐Mother ☐ Father ☐ Grandparent ☐ Brother/Sister ☐ Aunt/Uncle ☐Friend ☐ Other

Phone number 1: _____ Phone number 2: _____

Surname: _____First name: _____ Middle name: _____

Relationship to patient: ☐Mother ☐ Father ☐ Grandparent ☐ Brother/Sister ☐ Aunt/Uncle ☐Friend ☐ Other

Phone number 1: _____

Family History

Any relatives with clubfoot: ☐ Yes ☐ No ☐ Don't know ☐ If yes, how many: _____

Length of pregnancy (in weeks): _____ Complications during pregnancy: ☐Yes ☐No ☐Don't know

List complications: _____

Did the mother consume alcohol during pregnancy: ☐Yes ☐No ☐Don't know

Did the mother smoke during pregnancy: ☐Yes ☐No ☐Don't know

Any complications during birth: ☐Yes ☐No ☐Don't know

Referral Information

Referral source: ☐Hospital/Clinic ☐ Midwife ☐ Word of mouth ☐ Promotional materials ☐ Other ☐ Don't know

Specify: _____

Diagnosis

Feet affected:	☐ Left ☐ Right	☐ Both		
Diagnosis:	☐ Idiopathic clubfoot	☐ Syndromic clubfoot	☐ Neuropathic clubfoot	☐ Other
Deformity present at birth:	☐ Yes	☐ No	☐ Don't know	
Previous treatments:	☐ Yes	☐ No	☐ Don't know	How many: _____
Type of treatment(s):	☐ Casting above knee	☐ Casting below knee	☐ Physiotherapy	☐ Don't know ☐ Other
Diagnosed prenatally:	☐ Yes ☐ No	☐ Don't know	At week: _____	

Diagnosis comments:

Physical Examination

Abnormalities:	☐ Head	☐ Heart/Lungs	☐ Urinary/Digestive	☐ Skin	☐ Spine
	☐ Hips	☐ Upper extremities	☐ Lower extremities	☐ Neurological	
Any weakness:	☐ Arms	☐ Legs	☐ Other parts of body		

Comments:

Evaluator: _____ Evaluation date (dd/mm/yyyy): _____/_____/_____

Title of evaluator: ☐ Doctor ☐ PA ☐ Nurse ☐ Officer ☐Midwife ☐ Physical therapist ☐ Other

Patient Name: _____Patient Number: _____ Clinic: _____

PATIENT PROGRESS NOTES

DATE	NOTES

Patient Name: _____**Patient Number:** _____ **Clinic:** _____

Visit	**Visit 1**		**Visit 2**		**Visit 3**		**Visit 4**		**Visit 5**		**Visit 6**		**Visit 7**		**Visit 8**	
Date																
Evaluator																
	L	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**
Posterior crease																
Empty heel																
Rigid equinus																
HFC Score																
Talar head coverage																
Medial crease																
Curved lateral border																
MFC Score																
Total Score																
Treatment this visit																

Treatment Key: C-manipulation & casting; **T-**tenotomy; **B**-brace application; **R-**Refer; **S-**surgery, **O**-other (please give details in notes) **Scoring:** 0, 0.5, 1.0

Tenotomy	Yes ☐ No ☐	Date:	Measurement Left		Measurement Right	
Comments: Evaluator:			Degrees Dorsiflexion	Degrees Abduction	Degrees Dorsiflexion	Degrees Abduction

COMPLICATIONS

DATE	VISIT	DESCRIPTION OF COMPLICATION	TREATMENT OF COMPLICATION	RESULTS

Patient Name: _____ **Patient Number:** _____ **Clinic:** _____

Visit	**Visit 9**		**Visit 10**		**Visit 11**		**Visit 12**		**Visit 13**		**Visit 14**		**Visit 15**		**Visit 16**	
Date																
Evaluator																
	L	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**
Posterior crease																
Empty heel																
Rigid equinus																
HFC Score																
Talar head coverage																
Medial crease																
Curved lateral border																
MFC Score																
Total Score																
Treatment this visit																

Treatment Key: C-manipulation & casting; **T-**tenotomy; **B**-brace application; **R-**Refer; **S-**surgery, **O**-other (please give details in notes) **Scoring:** 0, 0.5, 1.0

Tenotomy	Yes ☐ No ☐	Date:	Measurement Left		Measurement Right	
Comments: Evaluator:			Degrees Dorsiflexion	Degrees Abduction	Degrees Dorsiflexion	Degrees Abduction

COMPLICATIONS

DATE	VISIT	DESCRIPTION OF COMPLICATION	TREATMENT OF COMPLICATION	RESULTS

Patient Name: ______________________________________**Patient Number:** _____________________ **Clinic:** ______________________________

BRACE COMPLIANCE

Visit	Compliance	Comments:	Action taken/Results:
	Good ☐ Fair ☐ Poor ☐ None ☐ Don't know ☐		
	Good ☐ Fair ☐ Poor ☐ None ☐ Don't know ☐		
	Good ☐ Fair ☐ Poor ☐ None ☐ Don't know ☐		
	Good ☐ Fair ☐ Poor ☐ None ☐ Don't know ☐		
	Good ☐ Fair ☐ Poor ☐ None ☐ Don't know ☐		
	Good ☐ Fair ☐ Poor ☐ None ☐ Don't know ☐		
	Good ☐ Fair ☐ Poor ☐ None ☐ Don't know ☐		
	Good ☐ Fair ☐ Poor ☐ None ☐ Don't know ☐		
	Good ☐ Fair ☐ Poor ☐ None ☐ Don't know ☐		
	Good ☐ Fair ☐ Poor ☐ None ☐ Don't know ☐		

Key: Good- Applies braces consistently as instructed; **Fair**- Goes days without brace; **Poor**- Goes weeks without brace; **None**- does not use brace.

SURGERY

Patient Name _____

Patient Number: _____

Date _____/_____/_____

Procedure performed:

- ☐ Per-Q Achilles tenotomy
- ☐ Open TAL/post release
- ☐ PMR
- ☐ Anterior tibialis transfer
- ☐ Other_____

Notes

Surgeon name and signature