

**General Information**

\*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 and marketing purposes: ( ) No ( ) Yes  
 \*Last name/Surname: \_\_\_\_\_ \*First name: \_\_\_\_\_ Middle name: \_\_\_\_\_  
 \*Sex: ( ) Male ( ) Female Race: ( ) Asian ( ) Caucasian (White) ( ) African (Black) ( ) Asian (Indian) ( ) Mixed ( ) Other  
 \*Date of birth (dd/mm/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Tribe: \_\_\_\_\_  
 Address 1: \_\_\_\_\_  
 Address 2: \_\_\_\_\_  
 Village/Town/City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Country: \_\_\_\_\_

**Parent/Guardian Information**

**Primary Parent/Guardian**

Last name/Surname: \_\_\_\_\_ First name: \_\_\_\_\_ Middle name: \_\_\_\_\_  
 Relationship to patient: ( ) Mother ( ) Father ( ) Grandparent ( ) Brother ( ) Sister ( ) Aunt ( ) Uncle ( ) Friend ( ) Other  
 \*Phone number 1: \_\_\_\_\_ Phone number 2: \_\_\_\_\_

**Secondary Parent/Guardian**

Last name/Surname: \_\_\_\_\_ First name: \_\_\_\_\_ Middle name: \_\_\_\_\_  
 Relationship to patient: ( ) Mother ( ) Father ( ) Grandparent ( ) Brother ( ) Sister ( ) Aunt ( ) Uncle ( ) Friend ( ) Other  
 Phone number 1: \_\_\_\_\_ Phone number 2: \_\_\_\_\_

Emergency contact: ( ) Primary ( ) Secondary ( ) Other

**Other Emergency Contact**

Last name/Surname: \_\_\_\_\_ First name: \_\_\_\_\_ Middle name: \_\_\_\_\_  
 Relationship to patient: ( ) Mother ( ) Father ( ) Grandparent ( ) Brother ( ) Sister ( ) Aunt ( ) Uncle ( ) Friend ( ) Other  
 Phone number 1: \_\_\_\_\_ Phone number 2: \_\_\_\_\_

**Family History**

Any relatives with the clubfoot deformity: ( ) Yes ( ) No If so, how many: \_\_\_\_\_  
 Length of pregnancy (in weeks): \_\_\_\_\_  
 Did the mother have any complications during pregnancy: ( ) Yes ( ) No  
 What were the complications: \_\_\_\_\_  
 Did the mother consume alcohol during pregnancy: ( ) Yes ( ) No  
 Did the mother smoke during pregnancy: ( ) Yes ( ) No  
 Any complications during birth: ( ) Yes ( ) No  
 Place of birth: ( ) Hospital ( ) Clinic ( ) Home

**Referral Information**

Referral source: ( ) Hospital/Clinic ( ) Midwife ( ) Word of mouth ( ) Promotional materials ( ) Other  
 Doctor name: \_\_\_\_\_ Hospital/Clinic name: \_\_\_\_\_ If Other, please specify: \_\_\_\_\_

**Diagnosis**

\*Name of evaluator: \_\_\_\_\_ \*Evaluation date (dd/mm/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_  
 \*Title of evaluator: ( ) Doctor ( ) Nurse ( ) Midwife ( ) Physical therapist ( ) Officer ( ) Other  
 \*Feet affected: ( ) Left ( ) Right ( ) Both  
 \*Diagnosis: ( ) Idiopathic clubfoot ( ) Syndromic clubfoot ( ) Neuropathic clubfoot ( ) Other  
 Deformity present at birth: ( ) Yes ( ) No  
 Any previous treatments: ( ) Yes ( ) No How many previous treatment sessions: \_\_\_\_\_  
 Type of previous treatment(s): [ ] Casting above knee [ ] Casting below knee [ ] Physiotherapy [ ] Other  
 Diagnosed prenatally: ( ) Yes ( ) No  
 At pregnancy week: \_\_\_\_\_  
 Confirmed at birth: ( ) Yes ( ) No  
 Diagnosis comments:

**Physical Examination**

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