

International Clubfoot Registry – New Patient form

Version 1.2

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