**Clubfoot Clinic Ortho Unit ll, Civil Hospital, Karachi**

**Patient form… Reg no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICR No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**General Information:**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: Male ( ) : Female ( )

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the parent or guardian consent to photographs of the patient being used for evaluation purpose( ) No ( ) Yes

**Parent/Guardian Information:**

**Primary Parent/ Guardian:**

Relationship to Patient: Mother ( ) Father ( ) Sibling ( ) Other ( ) Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CNIC No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

Any relatives with the clubfoot deformity: ( ) Yes ( ) No

Length of pregnancy (in weeks): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the mother have any complication during pregnancy: ( ) Yes ( ) No

What were the complications: ( ) Yes ( ) No

Did 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 ( ) Other

Doctor name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital/Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If other, please specify: \_\_\_\_\_\_\_\_\_\_

**Diagnosis:**

Name of evaluator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evaluation Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title of evaluator: ( ) Doctor ( ) Nurse ( ) Midwife ( ) Physical therapist ( ) other

Feet Affected: ( ) Right ( ) Left ( ) Both

Diagnosis: ( ) Idiopathic Clubfoot ( ) Syndromic Clubfoot ( ) Neuropathic Clubfoot ( ) Other

Deformity present at birth: ( ) Yes ( ) No

Any Pervious 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:**

[ ] Head [ ] Heart/Lungs [ ] Urinary/Digestive [ ] Skin [ ] Spine [ ] Hips

Any Abnormalities: [ ] Upper Extremities [ ] Lower Extremities [ ] Neurological

Any Weakness: [ ] Arms [ ] Legs [ ] Other Parts of Body

**Treatment Visit Form Diagnosis Feet affected**

**Initial Treatment Pirani Scores**

**Midfoot Score (MS) Curved Lateral Border (CLB) Medial Crease (MC) Lateral Head of Talus (LHT)**

**Hindfoot Score (HS) Posterior Crease (PC) Rigid Equinus (RE) Empty Heel (EH)**



Total no of Cast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total no of Recast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Tenotomy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Tenotomy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Brace Application: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Brace Application: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Completed Treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ : Date of Video:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ : Call Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Completed Treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ : Date of Video:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ : Call Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_