

# CURE Clubfoot Worldwide

## CLUBFOOT ASSESSMENT AND TREATMENT RECORD

Clinic Location: \_\_\_\_\_ Date: \_\_\_\_\_

CURE CLUBFOOT patient #: \_\_\_\_\_ Staff Name: \_\_\_\_\_

### Socio-demographic details:

Patient Name: \_\_\_\_\_  Male  Female

D.O.B.: \_\_\_\_\_ Tribe: \_\_\_\_\_ Place of birth:  Hosp  Clinic  Home

Parent/guardian name 1: \_\_\_\_\_ Contact: \_\_\_\_\_

Parent/guardian name 2: \_\_\_\_\_ Contact: \_\_\_\_\_

Other contact details: \_\_\_\_\_

### Patient History:

Are there any other relatives with clubfoot deformity? Specify relationship to child.

Was the child born with the deformity or did it develop after birth?

Any previous clubfoot treatment? Specify type (above/below knee) and number of casts.

Does the child have any weakness of the arms, legs or any other part of the body?

### Physical examination:

Spine: \_\_\_\_\_ Hips: \_\_\_\_\_ Neurological: \_\_\_\_\_

Upper extremities: \_\_\_\_\_ Lower extremities: \_\_\_\_\_

Feet affected:  Bilateral  Unilateral ( Right,  Left)

### Diagnosis:

Idiopathic clubfoot [ ]      Syndromic clubfoot [ ]      Neuropathic clubfoot [ ]

Recurrent clubfoot [ ]      Postural clubfoot [ ]      Metatarsus adduct [ ]



Patient Name: \_\_\_\_\_ Patient # \_\_\_\_\_ Clinic Location: \_\_\_\_\_

## CURE CLUBFOOT PATIENT TREATMENT RECORD

Appt. Date																
Age																
Visit:	1		2		3		4		5		6		7		8	
Foot:	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
PC																
EH																
RE																
<b>HFCS</b>																
MC																
LHT																
CLB																
<b>MFCS</b>																
<b>TS</b>																
<b>Treatment</b>																
Staff Name/s:																

**Pirani Score Key:** **PC**-Posterior Crease of ankle, **EH**-Emptiness of the Heel, **RE**-Rigidity of Equinus, **MC**-Medial Crease of the foot, **LHT**-Lateral part of the Head of Talus, **CLB**-Curvature of the Lateral Border of the Foot, **HFCS**-Hind Foot Contracture Score, **MFCS**-Mid Foot Contracture Score, **TS** – Total Score  
**Treatment Key:** **C**-manipulation & Casting; **T**-Tenotomy; **B**-Brace application (Foot Abduction Brace), **R**-Refer; **S**-Surgery, **O**-Other treatment (please give details).

### TREATMENT COMPLICATIONS

DATE	WEEK	DESCRIPTION OF COMPLICATION	TREATMENT OF COMPLICATION	RESULTS

**Guide for Appointment Dates:**      **Between casts:** 1-2 wks;      **After Tenotomy:** 3 wks;      **After 1st brace fitting:** 3 wks;      **After 1st brace review:** 5 wks  
**Brace wearing schedule:**      First 3 months: fulltime (except bathing)      Until Child is 3-4 yrs: nights only      Brace reviews every 3 months until 18 months, then every 6 months

Patient Name: \_\_\_\_\_ Patient # \_\_\_\_\_ Clinic Location: \_\_\_\_\_

## CURE CLUBFOOT PATIENT TREATMENT RECORD

Appt. Date																	
Age																	
Visit:	9		10		11		12		13		14		15		16		
Foot:	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	
PC																	
EH																	
RE																	
<b>HFCS</b>																	
MC																	
LHT																	
CLB																	
<b>MFCS</b>																	
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Staff Name/s:																	

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## BRACE COMPLIANCE PROBLEMS

(To be filled after each brace review)

Date:										
Brace Compliance:	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> None	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> None	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> None	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> None	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> None	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> None	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> None	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> None	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> None	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> None
No problems with brace: (tick if appropriate)										
Problems encountered: (please specify):										
Action taken:										

**Brace Compliance Key:**

Good: Applies brace consistently as instructed;

Fair: Makes significant effort to use brace (days without brace)

Poor: Irregular use of brace (weeks without brace);

None: No use of brace at all

**Potential problems key:**

NT- Child Not Tolerating FAB

SO- Feet keep Sliding Out of shoes (SO)

NA - Brace use Not Acceptable to parent

PU- FAB causes Pressure Ulcers

TS- Brace has become Too Small

O - Other (please specify)