

Firstname	Lastname	HAS ID _____
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Date	<input type="radio"/> Male <input type="radio"/> Female	DoB	Age (years) <input type="radio"/> Not sure
Event	Location	<input type="radio"/> Athlete <input type="radio"/> Unified partner	Sport
Delegation	SO Program		

Athlete Concerns/Previous Treatment or Surgery



Special Olympics

**Biomechanics, Joint Range of Motion, Skin, Nail and Toe Exam** (select all that apply)



Screener's name

Biomechanics	Left Foot			Right Foot		
	Val	N	Var	Val	N	Var
Over Pronator	<input type="radio"/>			<input type="radio"/>		
Supinator	<input type="radio"/>			<input type="radio"/>		
Normal	<input type="radio"/>			<input type="radio"/>		
Abducted	<input type="radio"/>			<input type="radio"/>		
Adducted	<input type="radio"/>			<input type="radio"/>		
Antalgic	<input type="checkbox"/>			<input type="checkbox"/>		
Crossover	<input type="checkbox"/>			<input type="checkbox"/>		
Foot Structure (Static)						
Pes Cavus	<input type="radio"/>			<input type="radio"/>		
Pes Planus	<input type="radio"/>			<input type="radio"/>		
Tibial Varum	<input type="checkbox"/>			<input type="checkbox"/>		
Metatarsus Adductus	<input type="checkbox"/>			<input type="checkbox"/>		
Calcaneus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Skin	Left Foot					Right Foot				
	1	2	3	4	5	1	2	3	4	5
Corns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calluses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heel				<input type="checkbox"/>					<input type="checkbox"/>	
Red				<input type="checkbox"/>					<input type="checkbox"/>	
Warts				<input type="checkbox"/>					<input type="checkbox"/>	
Papules				<input type="checkbox"/>					<input type="checkbox"/>	
Hyperhydrosis				<input type="checkbox"/>					<input type="checkbox"/>	
Ulcers				<input type="checkbox"/>					<input type="checkbox"/>	
Dry Skin				<input type="checkbox"/>					<input type="checkbox"/>	
Cracked				<input type="checkbox"/>					<input type="checkbox"/>	
Blisters				<input type="checkbox"/>					<input type="checkbox"/>	
Other				_____	<input type="checkbox"/>				_____	<input type="checkbox"/>
Other				_____	<input type="checkbox"/>				_____	<input type="checkbox"/>
Bone Deformities										
Hammertoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brachymetarsia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bunions				<input type="checkbox"/>					<input type="checkbox"/>	
Tailor's Bunion				<input type="checkbox"/>					<input type="checkbox"/>	
Haglunds				<input type="checkbox"/>					<input type="checkbox"/>	

Joint Range of Motion	Left Foot			Right Foot		
	Norm	Rstr	Flx	Norm	Rstr	Flx
Ankle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MTP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Subtalar	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Midtarsal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Nail	Toes					Toes				
	1	2	3	4	5	1	2	3	4	5
Mycosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ingrown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Shoe and Sock Exam and Shoe Size Measurement**

Screener's name

Shoe Type	<input type="text"/>	<input type="checkbox"/> Recommended	<input type="text"/>
Sock Type	<input type="radio"/> Acrylic <input type="radio"/> Wool <input type="radio"/> Cotton <input type="radio"/> Other <input type="radio"/> Nylon _____	<input type="checkbox"/> Acrylic <input type="checkbox"/> Wool <input type="checkbox"/> Cotton <input type="checkbox"/> Other <input type="checkbox"/> Nylon _____	
Shoe Size	<input type="text"/> Left <input type="text"/> Right <input type="radio"/> USA <input type="radio"/> Eng <input type="radio"/> Euro <input type="radio"/> Asia		

Measured shoe size?  Child  Adult

	Left				Right			
	USA	Euro	Engl	Asia	USA	Euro	Engl	Asia
Length	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Width	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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**Education, Review of Findings and Checkout**

Follow up care recommended?  No  Yes  FUNfitness

Prescribed OTC Treatment

Name of Physician Referred

**Gait Analysis (optional)** (select one on each foot)

*Right Foot*

**Backwards**

*Heel Strike*

	Val	N	Var	Val	N	Var
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tibia/Calca Angle.....	Val	N	Var	Val	N	Var
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Calca/Ground.....	Sup	N	Pro	Sup	N	Pro
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Midstance.....	Sup	N	Pro	Sup	N	Pro
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Propulsion.....	Abd	N	Add	Abd	N	Add
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Forwards</b>	Val	N	Var	Val	N	Var
Angle of Gait.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knee/Tibia.....	Val	N	Var	Val	N	Var
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Mat Scan and/or Video Gait Analysis:**

**Comments:**

Signature \_\_\_\_\_