

Station 1: Check In

First Name: _____ Last Name: _____ HAS ID: _____
 Event Date: ____/____/____ Date of Birth (mm/dd/yyyy): ____/____/____ Age (years): _____
 Event Location (City, State/Province or Country): _____ Delegation/SO Program: _____
 Gender: Female Male Prefer not to answer Athlete Status: Athlete Unified partner Non-athlete with IDD Other
 Sport: _____ Cell Phone: _____ Number is: Athlete's Parent's/Guardian's

Providing a phone number is optional. It will be used to send a text reminder if any follow-up is recommended after screening.

Select any/all current and/or previous medical history, diseases or injuries that apply to you and may affect screening results.	No conditions nor medical history that may affect this screening	I don't know	Did not answer		
	Heart problems	Problems with circulation	Skin problems, wounds	Fever, illness, infection	
	Current pain <i>If checked, please indicate where:</i>				
	Toes	Foot	Ankle	Lower leg/knee	Hip
	Current injury (e.g., sprain/strain) <i>If checked, please indicate where:</i>				
Toes	Foot	Ankle	Lower leg/knee	Hip	
Other history, disease, or injury					
On most days, do you have pain, aching, or stiffness in either of your feet?					
Yes	No	I don't know	Did not answer		
Have you ever been told by a doctor or other health worker that you have raised blood sugar or diabetes?					
Yes	No	I don't know	Did not answer		
Have you had an amputation of any part of your foot, ankle, or leg?					
Yes	No	I don't know	Did not answer		
<i>If yes, please indicate:</i>					
Left	Right	Both	Level (e.g., Below Knee Amputation, BKA): _____		
Do you typically wear a brace, orthotic, or prosthetic on either or both of your legs?					
Yes	No	I don't know	Did not answer		
<i>If yes, please indicate:</i>					
Left	Right	Both	Type (e.g., insole, AFO, etc.): _____		
Do you have regular foot checks with a doctor?					
Yes	No	I don't know	Did not answer		
<i>If yes, what is their specialty?</i>					
Podiatrist	Primary Care Provider	Physiotherapist	Dermatologist	Orthopedist	
Other (please specify): _____					
<i>When was your last visit:</i> _____					
In the past 12 months, how many times have you fallen?					
0 times	1 time	2 times	≥3 times	I don't know	Did not answer

Station 2: Shoe/Sock Exam & Measurement

Screener's Name: _____									
Current Shoe Size Record the athlete's current shoe size as printed on the shoes or reported. If width is unknown, select N/a.	Size type: USA EUR UK CM				Men	Women	Child		
	LENGTH:	LEFT:			N/a	RIGHT:			N/a
	WIDTH:	LEFT:			N/a	RIGHT:			N/a
Current Foot Size Measure the athlete's feet in centimeters (cm).	LENGTH (cm):			LEFT:		N/a	RIGHT:		N/a
	WIDTH (cm):			LEFT:		N/a	RIGHT:		N/a
Proper Shoe Size	Size type: USA EUR UK CM				Men	Women	Child		
	LENGTH:	LEFT:			N/a	RIGHT:			N/a
	WIDTH:	LEFT:			N/a	RIGHT:			N/a
Do the current shoes have a proper fit? (Current shoe size within 1 size greater or equal to proper shoe size (length).) Yes No If no, select which applies: Shoe too big Shoe too small				Is the current shoe in good condition? Yes No N/a			Are the current socks in good condition? Yes No N/a		
				Is the shoe appropriate for sport type? Yes No N/a			Are the socks appropriate for sport type? Yes No N/a		
Unable to test because athlete: Did not bring sizable shoes Refused to perform Unable to perform Unable to understand Other: _____									
Follow-up recommended? Yes No Check 'Yes' if 1) Athlete does not have proper fitting shoes (current shoe size is not within 1 size greater or equal to current foot size) and/or 2) if 'No' was checked on any of the condition/appropriateness for sport questions for shoes and socks. If 'Yes,' provide education regarding proper sizing, condition, and sport appropriateness (including MyHealth website resource).									

Station 3: Foot Assessment

Screener's Name: _____									
Structural Exam (select any/all that apply)									
Normal		Abnormal		Unable to test					
Toe deformities		Metatarsus adductus		Exostosis		Syndactyly (webbed toes)			
Hallux abducto valgus (bunions)		Hallux rigidus/limitus		Hallux varus		Plantar heel pain			
Brachymetatarsia (short toe)		Haglund's syndrome		Other					
Pain with any findings?		No	Yes	Did not answer					
Unable to test because athlete: Refused to perform Unable to perform Unable to understand Other: _____									
Follow-up recommended? Yes No Check 'Yes' if abnormal Structural Exam (i.e., Abnormal checked in top box) If yes, select appropriate follow-up recommendation below based on above findings: <u>Education Only:</u> Non-painful bunions/hammer toes/spurs (education to monitor and seek referral if become painful) <u>Non-Urgent Referral:</u> Cluster of > 3 findings suggesting possible pathology or pain									

Dermatological Exam (select any/all that apply)

Normal	Abnormal	Unable to test	
Wrong nail cut	Calluses	Moist skin	
Subungual hematoma	Wart(s)	Dry skin	
Split/Cracks	Blister(s)	Suspicious pigmented lesion	
Rash	Maceration	Dystrophic nails <i>(e.g., Split/lysis, thick, yellow, black, crumbly)</i>	
Odor	Lack of hair growth	Onychocryptosis (ingrown nail) Infected	Not infected

Pain with any findings? No Yes Did not answer

Unable to test because athlete:

Refused to perform Unable to perform Unable to understand Other: _____

Follow-up recommended?

Yes No

Check 'Yes' if abnormal Dermatological Exam (i.e., Abnormal checked in top box)

If yes, select appropriate follow-up recommendation below based on above findings:

Education Only: Poorly cut nails, non-painful calluses, blister(s), corn(s)

Non-Urgent Referral: Cluster of > 3 findings suggesting possible pathology or pain

Urgent Referral: Presence of any of the following:

Ulcer(s), acute subungual hematoma, suspicious pigmented lesion, signs of infection

Diabetic Foot Screen

History Question	Have you ever experienced any of the following in your lower legs/feet? Burning or tingling Changes in skin color or skin lesions Loss of sensation Slow healing None										
Pulses	Present		Absent		Unable to test						
	Dorsal Pedis pulse palpable?		LEFT:	Yes	No	N/a	RIGHT:	Yes	No	N/a	
	Posterior Tibial pulse palpable?		LEFT:	Yes	No	N/a	RIGHT:	Yes	No	N/a	
	<i>Unable to test because athlete:</i> <i>Refused to perform Unable to perform Unable to understand Other: _____</i>										
Palpation	Normal		Abnormal		Unable to test						
	Prominences or deformities present in above exams that could result in ulceration? <i>(e.g., bunions, hallux deformities, digital deformities, bumps on the heel, spurs on top of foot, etc.)</i>					LEFT:	Yes	No	RIGHT:	Yes	No
	Ulcer(s) or sore(s) present in above exams? <i>If yes, please indicate below:</i>					LEFT:	Yes	No	RIGHT:	Yes	No
	Is the ulcer(s) or sore(s) > 1cm?					LEFT:	Yes	No	RIGHT:	Yes	No
	Is the ulcer(s) or sore(s) infected?					LEFT:	Yes	No	RIGHT:	Yes	No
	Is the ulcer(s) or sore(s) located at midfoot or hindfoot?					LEFT:	Yes	No	RIGHT:	Yes	No
Can you see ligament or bone through the ulcer(s) or sore(s)?					LEFT:	Yes	No	RIGHT:	Yes	No	
<i>Unable to test because athlete:</i> <i>Refused to perform Unable to perform Unable to understand Other: _____</i>											

Protective Sensation	Present	Absent	Unable to test							
	Loss of protective sensation?		LEFT:	Yes	No	N/a	RIGHT:	Yes	No	N/a
	Test method used:		Ipswich	Semmes-Weinstein Monofilament						
	<i>Unable to test because athlete:</i> <i>Refused to perform</i> <i>Unable to perform</i> <i>Unable to understand</i> <i>Other: _____</i>									
LEFT SINBAD SCORE (0-6) = _____					RIGHT SINBAD SCORE (0-6) = _____					
Follow-up recommended? Yes No Check 'Yes' if abnormal Diabetic Foot Screen (i.e., Abnormal or Absent checked in top box of any sub-section) If yes, select appropriate follow-up recommendation below based on above findings: <u>Non-Urgent Referral:</u> If Abnormal or Absent is checked in top box of only one sub-section <u>Urgent Referral:</u> If Abnormal or Absent is checked in top box of multiple sub-sections, or if symptoms of Charcot-Marie-Tooth disease, ulcer(s) or open sore(s) with or without infection are present										

Station 4: Biomechanics

Screener's Name: _____

Static Biomechanics (Joint ROM/Structure)											
Non - Weight Bearing	Normal	Abnormal	Unable to test								
	Ankle ROM (WFL = within 10 - 25 degrees):										
	LEFT:	WFL	Hypermobile	Hypomobile	N/a	RIGHT:	WFL	Hypermobile	Hypomobile	N/a	
	1st MTP ROM (WFL = within 65 - 90 degrees):										
	LEFT:	WFL	Hypermobile	Hypomobile	N/a	RIGHT:	WFL	Hypermobile	Hypomobile	N/a	
	Pain with testing?		No	Yes	Did not answer						
	<i>Unable to test because athlete:</i> <i>Refused to perform</i> <i>Unable to perform</i> <i>Unable to understand</i> <i>Other: _____</i>										
Weight Bearing	Normal	Abnormal	Unable to test								
	Presence of Arch Deformity:										
	LEFT:	Yes	No	N/a	RIGHT:	Yes	No	N/a			
	<i>If yes, select:</i>		Pes Cavus	Pes Planus	<i>If yes, select:</i>		Pes Cavus	Pes Planus			
	Abnormal Calcaneal Position (WFL= within 5 degrees of neutral):										
	LEFT:	Yes	No	N/a	RIGHT:	Yes	No	N/a			
	<i>If yes, select:</i>		Varus	Valgus	<i>If yes, select:</i>		Varus	Valgus			
Pain with testing?		No	Yes	Did not answer							
<i>Unable to test because athlete:</i> <i>Refused to perform</i> <i>Unable to perform</i> <i>Unable to understand</i> <i>Other: _____</i>											

Follow-up recommended? Yes No Check 'Yes' if abnormal Static Biomechanics (i.e., Abnormal checked in top box of any sub-section) If yes, select appropriate follow-up recommendation below based on above findings: <u>Non-Urgent Referral:</u> Atypical ROM at BOTH ankle and 1st MTP joints (L or R) with or without pain, or atypical ROM at either ankle or 1st MTP joint (L or R) with pain										
---	--	--	--	--	--	--	--	--	--	--

Dynamic Biomechanics (Basic Gait Analysis)					
Normal	Abnormal	Unable to test			
		LEFT	RIGHT		LEFT RIGHT
Decreased step or stride length				Excessive pronation (<i>ever</i> sion > 10 degrees)	
Toe walking				Excessive supination (<i>in</i> version > 5 degrees)	
Abnormal hip or pelvic motion (<i>hip hike, drop, etc.</i>)				Forefoot abduction (<i>toe out</i> > 15 degrees)	
Early heel off				Forefoot adduction (<i>toe in</i> > 0 degrees)	
Pain with walking?	No	Yes	Did not answer		
<i>Unable to test because athlete:</i> Refused to perform Unable to perform Unable to understand Other: _____					
Follow-up recommended? Yes No Check 'Yes' if abnormal Dynamic Biomechanics (i.e., Abnormal checked in top box) If yes, select appropriate follow-up recommendation below based on above findings: <u>Non-Urgent Referral:</u> Athlete reports pain with walking (Abnormal gait without pain is not a recommended reason for referral)					

Station 5: Check Out

Screener's Name: _____

Screening Completion
 Was the screening unable to be completed and/or concluded prior to completion for any reason?
 Screening Complete Screening Incomplete
 If screening incomplete, please describe: _____

Extra resources provided onsite:
 Orthotics (Shoe Inserts): Low arch Neutral High arch
 Shoes Socks Shoe Laces Adaptive Laces Foot Hygiene Products Other: _____

Follow-up recommended? Yes No
If yes, please select appropriate provider(s) below. Select the most elevated referral type based on results of screening.

Podiatrist	Routine Follow-up	Continue routine care with a Podiatry provider at a frequency of: _____
	Non-Urgent Referral	<u>Reasons for Recommendation:</u> Pain Structural abnormalities Skin or nail abnormalities Abnormal gait Abnormal joint ROM Positive diabetic foot screen Other: _____
	Urgent Referral	<u>Reasons for Recommendation:</u> Pain Positive diabetic foot screen Ulcer, acute subungual hematoma, suspicious pigmented lesion, or signs of infection Other: _____
Please provide Name/Location of Referral: _____		Provider list dispensed

Primary Care Provider	Routine Follow-up	Continue routine care with a Primary Care Provider at a frequency of: _____
	Non-Urgent Referral	<u>Reasons for Recommendation:</u> Pain Structural abnormalities Skin or nail abnormalities Abnormal gait Abnormal joint ROM Positive diabetic foot screen Other: _____
	Urgent Referral	<u>Reasons for Recommendation:</u> Pain Positive diabetic foot screen Ulcer, acute subungual hematoma, suspicious pigmented lesion, or signs of infection Other: _____
	Please provide Name/Location of Referral: _____	
Physiotherapist	Routine Follow-up	Continue routine care with a Physiotherapy provider at a frequency of: _____
	Non-Urgent Referral	<u>Reasons for Recommendation:</u> Pain Structural abnormalities Abnormal gait Abnormal joint ROM Other: _____
	Please provide Name/Location of Referral: _____	
Other (please specify): _____	Non-Urgent Referral	<u>Reasons for Recommendation:</u> _____
	Urgent Referral	<u>Reasons for Recommendation:</u> _____
	Please provide Name/Location of Referral: _____	