Firstname	**Lastname**	**HAS ID** ____ ____ _____ ____ ____

Date	**O Male O Female**	**DOB**	**Age (years) O Not sure**
Event	Location	O Athlete O Unified partner	Sport
Delegation/County		SO Program	
Cell phone number		**Number is O Athlete's O Parent's / Guardian 's**	
Providing a phone number is optional. It may be used to call or send reminders if follow up is recommended after screening.			

Athlete Concerns/Previous Treatment or Surgery:
Weight _____ lbs. ____ oz. *Measure up to ½ oz* Weight _____•___ kgs *Measure up to .01 kg*

Special Olympics **Fit Feet**

Shoe Exam and Shoe Size Measurement

Screeners Name:

Amputee	**Prosthetics**
Left	**Left**
O Yes O No	O Yes O No
Right	**Right**
O Yes O No	O Yes O No

Current shoe size? O Child O Adult

	Left				Right			
	USA	Euro	UK	Asia	USA	Euro	UK	Asia
Length								
Width								

Current Shoe Type		***Current Sock Type***	
O Sport	O Sandal	O Acrylic	O Wool
O Casual	O Custom	O Cotton	O Other
O Boots		O Nylon	O No Sock

Measured shoe size? O Child O Adult

	Left				Right			
	USA	Euro	UK	Asia	USA	Euro	UK	Asia
Length								
Width								

Skin, Nail, Toe and Foot Exam (Select all that apply)

Screener's Name:

Nail		**Skin**				**Foot and Bone**	
☐	Normal	☐	Normal	☐	Ulcers	☐	Normal
☐	Wrong nail cut	☐	Calluses	☐	Papules	☐	Crossover toe
☐	Hematoma	☐	Warts	☐	Nevus	☐	Clawtoes
☐	Lesion	☐	Blisters	☐	Rash	☐	Brachymetatarsia (Short toe)
☐	Discoloration	☐	Maceration	☐	Soft tissue mass	☐	Bunions
☐	Split and laceration	☐	Split/cracks	☐	Corns -	☐	Tailor's bunions
☐	Thick	☐	Redness			☐	Hallux rigidus/limitus
☐	Yellow	☐	Moist			☐	Neuralgia
☐	Black	☐	Dry			☐	Haglunds
☐	White	☐	Odor			☐	Exostosis
☐	Blister					☐	Hammertoes
☐	Crumbly					☐	Syndactyly
☐	Ingrown					☐	Hallus Varus

Firstname	Lastname	HAS ID _____ _____ _____ _____ _____

Biomechanics, joint range of motion
Static Biomechanics

Screener's Name:

Tekscan Provided? ___ Yes ___ No

Joint range of motion	*Left Foot*				*Right Foot*			
	Norm	*Rst*	*Hypermobile*	*N/A*	*Norm*	*Rst*	*Hypermobile*	*N/A*
Ankle	O	O	O	O	O	O	O	O
MTP	O	O	O	O	O	O	O	O
Subtalar	O	O	O	O	O	O	O	O
Midtarsal	O	O	O	O	O	O	O	O
Knee	*Val* *O*	*N* *O*	*Var* *O*	O	*Val* *O*	*N* *O*	*Var* *O*	O
	Recurvatum *O*		*Flexum* *O*	O	*Recurvatum* *O*		*Flexum* *O*	O

Foot structure	*Left Foot*			*Right Foot*		
Pes Cavus	O			O		
Pes Planus	O			O		
Metatarsus Adductus	☐			☐		
Tibial varum	☐			☐		
Calcaneus	O Val	O N	O Var	O Val	O N	O Var
N/A	O			O		

Basic Gait Analysis	*Left Foot*	*Right Foot*
Normal	☐	☐
Excessive Pronation	☐	☐
Excessive Supination	☐	☐
Forefoot Abduction	☐	☐
Forefoot Adduction	☐	☐
Early Heel	☐	☐
N/A	☐	☐

Education, Review of Findings and Checkout

Screener's Name:

Follow up care recommended? ___ Yes O Urgent O Not Urgent
___ No (**if NO, submit HAS form only)**

Referral Made to: O Podiatrist O Physician O Physiotherapist O Pedicure O Orthopedist O Other

☐ **Name/Location of Physician Referred** _____

LOCK LACES provided? ___ Yes ___ No
SOCKS Provided? ___ Yes ___ No
CREAM Provided? ___ Yes ___ No
POWDER Provided? ___ Yes ___ No
SHOES Provided? ___ Yes ____ No

Athlete already has Insoles: ◯ Yes ◯ No
OTC Insoles Dispensed? ◯ Yes ◯ No

Size: _____ Men Women Child
(circle one)

Comments: