Pediatric Orthopedic Intake
Practitioner Form

Date of Screening: _____ Location of Screening:_____

Childs Name: _____ Screening Practitioner:_____

Age: **Height:** **Weight:** **Current Shoe Size:**

Developmental History:

History of Delayed ambulation_____, if yes how long_____
History of Toe Walking _____, if yes how long_____
History of In-Toe Walking_____, if yes how long_____
History of Impaired Balance or Clumsiness_____, if yes how long_____
History of excessive growing pains_____, if yes how long_____
History of vision issues_____, if yes how long_____
Other Prior history of _____, if yes how long_____

Pain: _____

Orthopedic, Pediatrician, or other Treatment History:

Current Status:

Complaints of Pain:

Balance:

Coordination:

Flexibility:

Speed:

Endurance:

Current Treatments:

Orthotics and Splints (patient):

Any prior devices used to treat this child?
Were they helpful?

Orthotics and Splints (parent):

Any prior devices used to treat either parent?
Were they helpful?

Foot Type of Patient:

Foot Type of Parent/s:

Orthopedic Physical Exam Findings:

Hip:

Knee:

Tib/Fib:

Ankle:

STJ/Foot:

Limb Length:

Arch Height:

Toe Sign:

Gait Type:

Callus pattern:

Intoeing & Why:

Toe-Walking & Why:

Current Recommendations: (make these check boxes with lines for notes afterwards)

- ☐ Stretching Program:_____
- ☐ Physical Therapy:_____
- ☐ Night Splints:_____
- ☐ Prefab Orthotics:_____
- ☐ Gait Plates:_____
- ☐ Custom Foot Orthotics:_____
- ☐ SMO's:_____
- ☐ AFO's:_____

Follow UP Plan:

____No Further follow up needed
____Xrays
____Schedule full office Exam
____Follow up on treatment recommendations in ____wks / months