John Doe Chiropractic & Wellness Center
Dr. John Doe
1010 Any Street, Suite 100
Any Town, HT 12345

FUNCTIONAL FOOT EXAMINATION

Patient's Name _____ **Doctor's Name** _____ **Date of Examination:** _____

FOOT EXAMINATION(S) PERFORMED

☐ **Inspection** ☐ **Palpation** ☐ **Alignment Weight Bearing** ☐ **Range of Motion** ☐ **Neurology** ☐ **Gait Analysis**
☐ **Digital Foot Evaluation** ☐ **Bilateral Foot Cast**

NOTES/COMMENTS:

OBJECTIVE FINDINGS

INSPECTION: PRESENT OR ABSENT | RIGHT OR LEFT

☐ *Abnormal Shoe Wear [P/A] [R/L] ☐ Limp [P/A] [R/L] ☐ Brace (Ace, Tape, Splint, Cast, Boot) [P/A] [R/L] ☐ Ambulatory Aid (Crutches, Cane, Walker) [P/A] [R/L]
☐ Plantar Warts [P/A] [R/L] ☐ Edema (Unilateral / Bilateral) [P/A] [R/L] ☐ Ecchymoses [P/A] [R/L] ☐ Toes ☐ Excessive Callus Formation [P/A] [R/L]

PALPATION: +/- | RIGHT OR LEFT

☐ Pes Planus [Flexible +/- | R/L] [Rigid +/- | R/L] ☐ Pain _____[R/L] ☐ Pitting Edema [+/- | R/L] ☐ Joint Fixation _____[R/L]

ALIGNMENT WEIGHT BEARING: PRESENT OR ABSENT | RIGHT OR LEFT

☐ Pronation [P/A] [R/L] ☐ Supination [P/A] [R/L] ☐ Pes Planus [P/A] [R/L] ☐ Pes Cavus [P/A] [R/L] ☐ Forefoot Varus [P/A] [R/L]
☐ Forefoot Valgus [P/A] [R/L] ☐ Calcaneal Valgus [P/A] [R/L] ☐ Calcaneal Varus [P/A] [R/L] ☐ Genu Varus [P/A] [R/L]
☐ *Genu Valgum (Inward Knee Rotation) [P/A] [R/L] ☐ Leg Length Inequality [P/A] [R/L] ☐ *Foot Flare [P/A] [R/L]

RANGE OF MOTION: MEASURED IN DEGREES | SENSORY: NORMAL, UP, DOWN

☐ Ankle Dorsiflexion _____ ☐ Ankle Plantar Flexion _____ ☐ Ankle Inversion _____ ☐ Ankle Eversion _____

NEUROLOGY: GREATER NUMBER IS BEST

☐ Heel Walking 1 | 2 | 3 | 4 | 5 ☐ Toe Walking 1 | 2 | 3 | 4 | 5 ☐ Ankle Inversion & Dorsiflexion 1 | 2 | 3 | 4 | 5 ☐ Great Toe Extension 1 | 2 | 3 | 4 | 5
☐ Toe Flexion 1 | 2 | 3 | 4 | 5 ☐ Sensory L4 [N INCREASED DECREASED] ☐ Sensory L5 [N INCREASED DECREASED] ☐ Sensory S1 [N INCREASED DECREASED]
☐ Reflex Achilles 1 | 2 | 3 | 4 | 5 ☐ Reflex Babinski's [P/A]

☐ *Helbing's Sign (Bowed Achilles Tendon) [P/A] [R/L] ☐ *Navicular Drop (Low Medial Arch) [P/A] [R/L] _____mm ☐ Anterior Drawer Test [+/- | R/L]
☐ Posterior Drawer Test [+/- | R/L] ☐ Valgus Stress Test [+/- | R/L] ☐ Varus Stress Test [+/- | R/L] ☐ Thompson's Test [+/- | R/L] ☐ Morton's Test [+/- | R/L]
☐ Mosses Test [+/- | R/L] ☐ Tinnel's Test [+/- | R/L]

NOTES/COMMENTS:

* Indicates Signs of Excessive Pronation

PROFESSIONAL CARE AND PATIENT CARE

PROFESSIONAL CARE - What has been prescribed by previous physician(s)?

☐ Brace/Splint _____ ☐ Rx _____
☐ Therapeutic Exercise _____ ☐ Cortisone Injection_____
☐ Surgery _____

PATIENT CARE - What has the patient tried on their own?

☐ Massage _____ ☐ Soaking the Feet (Foot Bath) _____
☐ Icing _____ ☐ Padding _____
☐ Accommodating Foot Wear _____ ☐ NSAIDS _____
☐ OTC Orthotics _____

NOTES/COMMENTS:

FUNCTIONAL FOOT EXAMINATION

Signature of Provider _____ **Date** _____