

# PODIATRY TREATMENT RECORD

Practice Name & Address

PLEASE COMPLETE THE FOLLOWING IN INK USING BLOCK CAPITALS

<b>PATIENT CONTACT DETAILS</b>	Surname (Mr / Mrs / Miss)		
	Forenames		
	Address		Postcode
	Home Telephone	Work Telephone	
	Change of Address		Postcode

<b>CONTACTS</b>	Next of Kin's Name	Telephone
	Doctor's Name	
	Doctor's Address	Postcode
	Change of Doctor	

<b>PATIENT DETAILS</b>	Date of Birth		Marital Status (Married / Single / Widowed / Divorced)			
	Height	ft	ins	Weight	st	lbs
		cms			kgs	
	Occupation			Previous Occupation		
	Name of School (if school child)					
	Transport Requirements (please tick as required)		Ambulance	Hospital Car	Public Transport	
		Voluntary Car	Own Transport	Domiciliary		

<b>FOOTWEAR</b>	Footwear Appraisal	Shoe Size
		Type Worn

<b>HISTORY</b>	Has Patient had Podiatry Treatment in the Last Year? (Yes / No)	Last Treatment Date
	Name of Podiatrist/Clinic Attended (if YES above)	
	Reason for Last Treatment	

# PRIMARY ASSESSMENT & EXAMINATION (A)

Patient Name

## PRIMARY COMPLAINT

Chief Concern  
(in patient's own words)

## MEDICAL HISTORY

Illness

Operations

Injuries

Allergies

Familial

Social

## DRUG THERAPY

Current Medication  
(if none, please state)

## FOOT PATHOLOGY

Foot Pathology (Nature / Location / Duration / Onset / Course / Aggravated By)

Right

Left

# PRIMARY ASSESSMENT & EXAMINATION (B)

Patient Name

<b>PERIPHERAL VASCULAR</b>	Peripheral Vascular Examination (Colour / Temperature / Pulses / Trophic Changes / Veins)					
	Right			Left		

<b>NEUROLOGICAL</b>	Neurological Examination (Reflexes / Deep Reflexes / Touch, Heat, Vibration and Pain Sensation)					
	Right			Left		
	Patella	Achilles	Plantar Response	Patella	Achilles	Plantar Response

<b>SKIN</b>	Skin Survey (Lesions / Pigmentation / Nail Conditions / Hair & Skin / Glands)					
	Right			Left		

<b>ORTHOPAEDIC</b>	Orthopaedic Assessment (General Overview / Range of Motion / Rigidity / Stance / Gait)					

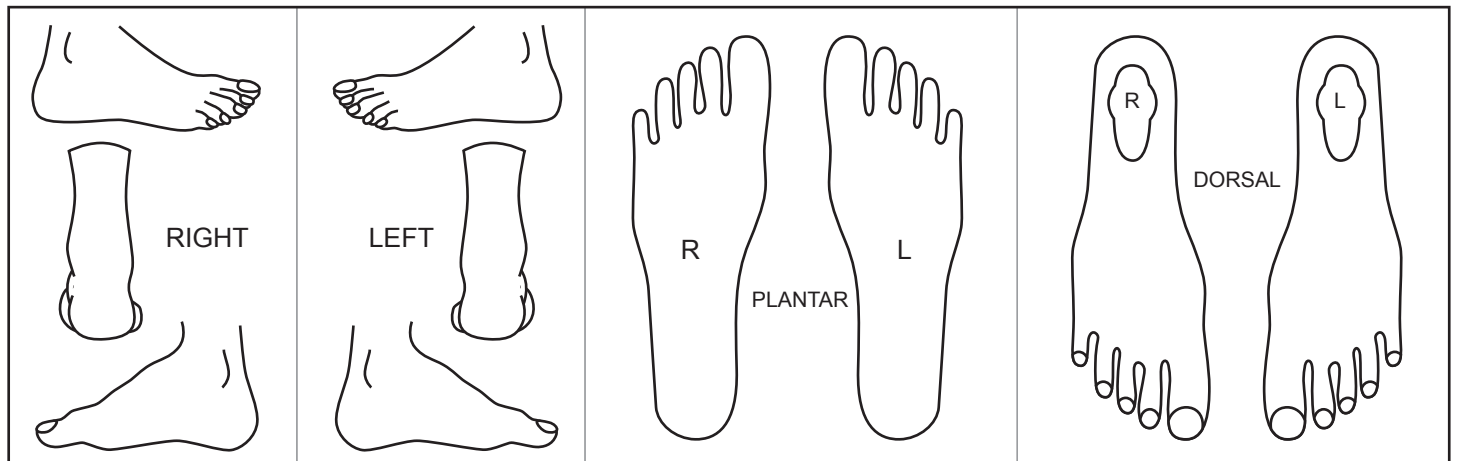
<b>TESTS</b>	Gait Analysis		Biomechanical Evaluation		X-Ray
	Pathology Lab		Other		



# PODIATRY TREATMENT PROGRAMME

Sheet no.

Patient Name



Date	S.O.A.P. Progress Report and Treatment	Clinician

ALL ENTRIES MUST FOLLOW THE S.O.A.P. FORMAT  
**S**UBJECTIVE, **O**BJECTIVE, **A**SSASSESSMENT, **P**LAN