DATE:

PHYSIO:

Patient Assessment Form
GENERAL

PATIENT NAME: F/Name REGISTRATION NUMBER:

PATIENT HISTORY:

ADDRESS (Province-District) :			PHONE N°:	
PATIENT AGE:		F	M	Diagnosis:
1.	Civil Status	Single	Married	Number of children:

2.	Job & Occupation	Armed forces	Farmers, fisherman	Non qualified worker	Technician
		Office workers	Retired	Unemployed & not active	Student

3.	Education level	Can write	Can read	Class:

4.	History of the trauma/illness	Date:	Circumstances/Etiology:
	Associated diseases:		

5.	Medical History/Treatment	Hospital:		Care:
	Evolution since the beginning	Improved	Worse	Remarks:
	Medication:			X-ray/Other ex:

6.	Psychological Status			
	Motivation/Emotional Status	Good	Bad	Comments:
	Attitude/Compliance	Good	Bad	Comments:
	Cognitive Status and others *(Mainly for Neurological Conditions)*			
	Concentration/Memory	Good	Bad	Comments:
	Communication (understanding, speaking)	Good	Bad	Comments:
	Bowel/Bladder control	Yes	No	Comments:
	Swallowing	Good	Bad	Comments:
	Breathing (ability to cough)	Good	Bad	Comments:
	Vision	Good	Bad	Comments:
	Hearing	Good	Bad	Comments:

7.	Living Condition			
	House	Good	Bad	Comments:

	Environment	Rural	Urban	Mountain	Flooded fields

	Family	Present	Absent	Comments:
	Friends	Present	Absent	Comments:
	Cultural Environment	Supportive	Limitative	Comments:

8.	Medical and Social Support			
	Accessibility to Medical Services	Yes	No	Comments:
	Accessibility to Social Services	Yes	No	Comments:
	Security Situation	Good	Bad	Comments:

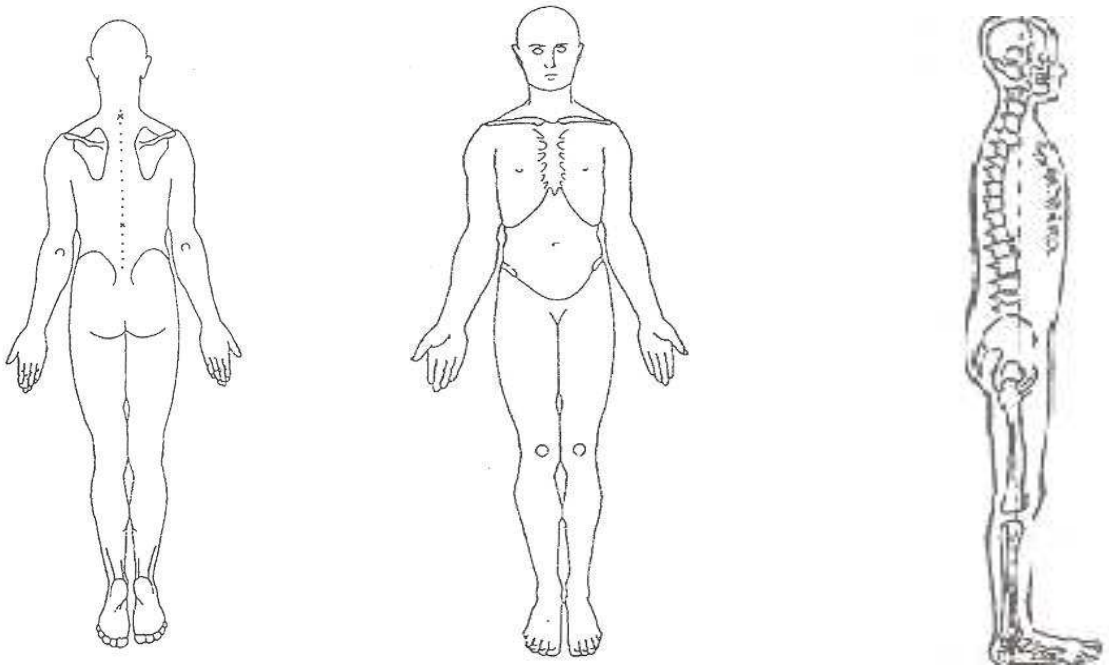
9.	Main patient's concerns:
10	Main patient's expectations:

Current Treatment:	1st	2nd	3rd/ >

Remarks:

Physical Examination:

Mark on the body-chart deformities or joint anomalies, back deformities or anomalies, edema, shoulder subluxation etc.



Remarks:

Skin & soft tissues problem

DISORDERS	Minor	Important
Swelling		
Callus		
Scar		
Wound		
Temperature		
Infection		
Pain		
Abnormal Sensation		

Sensation

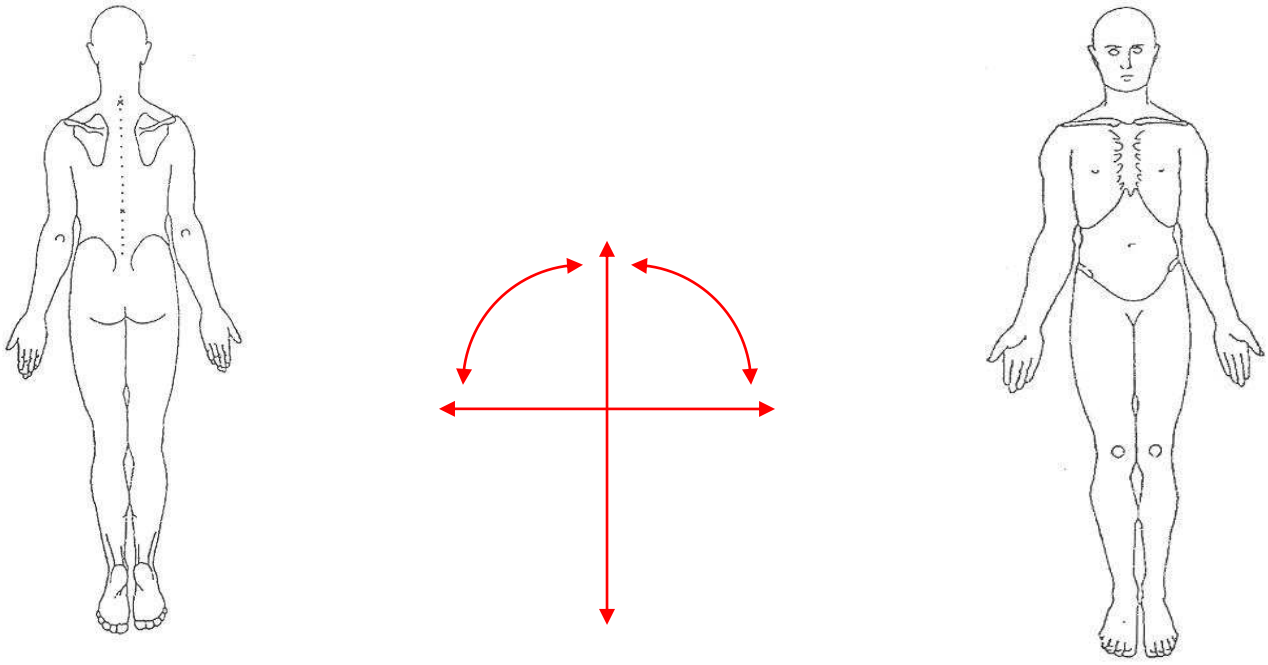
Sensitivity	R	L	(Specification)
Superficial			
Deep			
Numbness			
Paresthesia			
Other			

Reflexes

	R			L			Comments
BTR	+	-	normal	+	-	normal	
TTR	+	-	normal	+	-	normal	
KTR	+	-	normal	+	-	normal	
ATR	+	-	normal	+	-	normal	
Babinsky							

+ Hyper reflex; **-** Hypo reflex

Body chard of pain/symptoms distribution:



Pain:

Date of first complains:

Evolution since the beginning of the pain:

Evolution in 24h & scale 0 -10:

Pain ↑ (increase) with:

Pain ↓ (decrease) with:

Patient's category	SIN	ROM	MOMP	EOR

SIN: severe,irritable,nature **ROM**: range of motion **EOR**: end of range **MOMP**: momentary pain

Neurodynamics

Tests	R	L	Sensitive component
SLR			
Slump			
PKB			
ULNT1			
ULNT2			
ULNT2			
ULNT3			

Range Of Motion:

- Passive ROM should be recorded during first assessment and before discharging the patients

LOWER LIMB			DATE Assessment ----------		DATE Follow up ----------	
			L	R	L	R
HIP						
	Flexion	120				
	Extension	30				
	Abduction	45				
	Adduction	30				
	Medial Rotation	30				
	Lateral Rotation	60				
KNEE						
	Flexion	135				
	Extension	0				
ANKLE-FOOT						
	Dorsi Flexion	30				
	Plantar Flexion	45				
	Inversion	35				
	Eversion	15				
NECK						
	Flexion	cm				
	Extension	cm				
	Latero-Flexion R	cm				
	Latero-Flexion L	cm				
	Rotation R	cm				
	Rotation L	cm				
TRUNK						
	Global Flexion	cm				
	Thoracic Flexion (OttTest)	cm				
	Lumbar Flexion (Schober test)	cm				
	Global Extension	cm				
	Latero-Flexion R	cm				
	Latero-Flexion L	cm				
	Rotation R (write OK or imp.)					
	Rotation L (write OK or imp.)					

UPPER LIMB			DATE Assessment ----------		DATE Follow up ----------	
			L	R	L	R
SHOULDER						
	Flexion	180				
	Extension	60				
	Abduction	180				
	Adduction	30				
	Medial Rotation	95				
	Lateral Rotation	80				
ELBOW						
	Flexion	150				
	Extension	0				
FOREARM						
	Pronation	80				
	Supination	80				
WRIST						
	Flexion	80				
	Extension	80				
	Abduction	20				
	Adduction	35				
FINGERS						
	Thumb opposition					
	MP Flexion	90				
	MP Extension	40				
	IP Flexion	120				

Remarks:

Muscle Test:

- Muscle test should be recorded during first assessment and before discharging the patient

LOWER LIMB		DATE Assessment ----------		DATE Follow up ----------	
		L	R	L	R
HIP	**Comments**				
Flexors					
Extensors					
Abductors					
Adductors					
Lateral Rot.					
Medial Rot.					
KNEE					
Flexors					
Extensors					
ANKLE					
Dorsi Flex.					
Plantar Flex.					
Inversors					
Eversors					
FOOT					
Flexors					
Extensors					
TRUNK					
Flexors					
Extensor					
R. Bending					
L. Bending					
R. Rotation					
L. Rotation					

UPPER LIMB		DATE Assessment ----------		DATE Follow up ----------	
		L	R	L	R
SHOULDER	**Comments**				
Flexors					
Extensors					
Abductors					
Adductors					
Lateral Rot.					
Medial Rot.					
Elevators					
Depressors					
Antepulsors					
Retropulsors					
ELBOW					
Flexors					
Extensors					
FOREARM					
Supinators					
Pronators					
WRIST					
Flexors					
Extensors					
FINGERS					
Flexors					
Extensors					
Abductors					
Opposition					

QUOTATION FOR MUSCLE TESTING according to Manual Muscle Testing Oxford Scale	
0	*No contraction present*
1	*Contraction visible without movement*
2	*Movement possible without gravity or incomplete against gravity*
3	*Movement possible against gravity into the fullest available range*
4	*Movement possible against gravity and an added moderate resistance*
5	*Muscle functions normally*

Muscle Tone:

- Muscle test should be recorded during first assessment and before discharging the patient

LOWER LIMB		DATE Assessment ----------		DATE Follow up ----------	
		L	R	L	R
HIP	**Comments**				
Flexors					
Extensors					
Abductors					
Adductors					
Lateral Rot.					
Medial Rot.					
KNEE					
Flexors					
Extensors					
ANKLE					
Dorsi Flex.					
Plantar Flex.					
Inversors					
Eversors					
FOOT					
Flexors					
Extensors					
TRUNK					
Flexors					
Extensor					
R. Bending					
L. Bending					
R. Rotation					
L. Rotation					

UPPER LIMB		DATE Assessment ----------		DATE Follow up ----------	
		L	R	L	R
SHOULDER	**Comments**				
Flexors					
Extensors					
Abductors					
Adductors					
Lateral Rot.					
Medial Rot.					
Elevators					
Depressors					
Antepulsors					
Retropulsors					
ELBOW					
Flexors					
Extensors					
FOREARM					
Supinators					
Pronators					
WRIST					
Flexors					
Extensors					
FINGERS					
Flexors					
Extensors					
Abductors					
Opposition					

QUOTATION FOR MUSCLE TONE according to Modified Ashworth Scale	
0	*No increase in tone*
1	*Slight increase in tone giving a catch when limb is moved*
2	*More marked increase in tone*
3	*Considerable increase in tone – passive movement difficult*
4	*Limb rigid*
Write ⇩ in case of hypotone (flaccidity)	

Functional Evaluation:

Balance disorders

Sitting	Normal
	Good
	Poor
	Not possible
Standing	Normal
	Good
	Poor
	Not possible

Coordination

UPPER LIMBS	Good		Poor		Not possible	
	L	**R**	**L**	**R**	**L**	**R**
LOWER LIMBS	Good		Poor		Not possible	
	L	**R**	**L**	**R**	**L**	**R**
Comments:						

Gait Analysis

FRONTAL PLANE
Observations :

SAGITTAL PLANE
Observations :

Functional Quality of the gait	Normal	Good	Poor	Comments:
1. **SAFETY**				
2. **CADENCE**				
3. **SPEED**				
4. **FATIGUE**				

Other Remarks:

Activity Limitations & Participation Restrictions

ACTIVITIES / PARTICIPATIONS			Independent	Assisted	Impossible	
MOBILITY						
	Crawling		☐	☐	☐	
	Crouching gait		☐	☐	☐	
	Walking		☐	☐	☐	
	Squatting		☐	☐	☐	
	Stairs		☐	☐	☐	
	Running		☐	☐	☐	
TRANSFERS						
	Lie to Sit (& opposite)		☐	☐	☐	
	Sit to Stand (& opposite)		☐	☐	☐	
	Stand to Floor (& opposite)		☐	☐	☐	
	Sit to sit		☐	☐	☐	
BALANCE						
	Sitting		☐	☐	☐	
	Standing		☐	☐	☐	
	On one leg		☐	☐	☐	
UPPER LIMB FUNCTIONS						
	Grasp	R	☐	☐	☐	
		L	☐	☐	☐	
	Release	R	☐	☐	☐	
		L	☐	☐	☐	
	Fine Manipulation	R	☐	☐	☐	
		L	☐	☐	☐	
	Holding	R	☐	☐	☐	
		L	☐	☐	☐	
		R	☐	☐	☐	
		L	☐	☐	☐	
DAILY LIFE ACTIVITIES						
	Dressing – Upper body		☐	☐	☐	
	Dressing – Lower body		☐	☐	☐	
	Toileting		☐	☐	☐	
	Bathing		☐	☐	☐	
	Washing oneself		☐	☐	☐	
	Eating		☐	☐	☐	
	Drinking		☐	☐	☐	
			☐	☐	☐	

ASSISTED DEVICES									
	Without assisted devices	☐							
	One crutch	☐	Good	Bad					
	Pair of crutches	☐	Good	Bad					
	Walking frame	☐	Good	Bad					
	Wheelchair	☐	Good	Bad					
	Orthoses right side	☐	Good	Bad	FO	AFO	KAFO	HKAFO	Shoe raise
	Orthosis left side	☐	Good	Bad	FO	AFO	KAFO	HKAFO	Shoe raise

CONCLUSION OF PATIENT ASSESSMENT & MAIN FINDINGS	
ENVIRONMENTAL & PERSONAL FACTORS	
Personal conditions	
Living conditions	
Med & Social structures	
Current treatment	
Remarks	
BODY STRUCTURE & FUNCTION IMPAIRMENTS	
Ass. trauma & diseases	
R.O.M status	
Muscle status	
Skin & soft tissues/Pain	
Cardio vascular status	
ACTIVITY LIMITATIONS & PARTICIPATION RESTRICTION	
General Mobility (gait)	
Transfers	
Balance	
Upper limb functions	
Daily life activities	

REFERRAL		
Referred to…… For	☐ Medical care ☐ Medication ☐Orthopaedic consultation ☐ Orthopaedic surgery ☐ Other (specify)	☐ Nursing care ☐ Remove cast ☐ Stump revision ☐ Tenotomy

TREATMENT PLAN

Walking Aids			Wheelchairs and Modifications	
☐ Axillary crutches ☐ Elbow crutches ☐ Cane ☐ Walking frame	☐ Adult ☐ Child	☐ Pair ☐ Unit	☐ Wheelchair 3-wheels ☐ Wheelchair 4-wheels ☐ Tricycle	☐ Wheelchair 3-wheels and modifications ☐ Wheelchair 3-wheels and seating system ☐ Wheelchair 4-wheels and modifications ☐ Wheelchair 4-wheels and seating system

Other	☐ Standing Frame ☐ Baby walker	☐ Other (specify)

Lower Limb Prostheses		Upper Limb Prostheses	
☐ Partial Foot ☐ Ankle Disarticulation ☐ Trans Tibial	☐ Trans Femoral ☐ Knee Disarticulation ☐ Hip Disarticulation	☐ Shoulder Disarticulation ☐ Trans Humeral	☐ Trans Radial ☐ Elbow Disarticulation

Lower Limb Orthoses	Upper Limb Orthoses	Spinal Orthoses
☐ Shoe Raise ☐ Foot Orthosis ☐ AFO ☐ KAFO ☐ Knee Orthosis (KO) ☐ Hip Orthosis (HO) ☐ HKAFO	☐ Shoulder Orthosis (SO) ☐ Shoulder Elbow Hand Orthosis (SEHO) ☐ Elbow Orthosis (EO) ☐ Wrist Hand Orthosis (WHO) ☐ Finger Orthosis	☐ Cervical Orthosis (CO) ☐ Lumbo Sacral Orthosis (LSO) ☐ Thoraco Lumbo Sacral Orthosis (TLSO) ☐ Cervico Thoraco Lumbo Sacral Orthosis (CTLSO)

Technical Specifications :

PHYSIOTHERAPY TREATMENT PLAN

Treatment Objectives

SHORT TERM:

MID TERM:

LONG TERM:

Treatment Proposals

Follow up Plan:
(How often pat needs FU?)

Date follow up appointment:

PHYSIOTHERAPY FOLLOW UP

DATE: _____ **PHYSIO NAME:** _____ **OT NAME:** _____	**Current situation of the patient** (Improvement-goals achieved, functional status, ROM-Muscle strength etc., compared to previous assessment)
	Treatment Proposals
NEXT FOLLOW UP (OP): _____	**Remarks:**
DATE: _____ **PHYSIO NAME:** _____ **OT NAME:** _____	**Current situation of the patient** (Improvement-goals achieved, functional status, ROM-Muscle strength etc., compared to previous assessment)
	Treatment Proposals
NEXT FOLLOW UP (OP): _____	**Remarks:**

PHYSIOTHERAPY FOLLOW UP

DATE: _____

PHYSIO NAME: _____

OT NAME: _____

Current situation of the patient
(Improvement-goals achieved, functional status, ROM-Muscle strength etc., compared to previous assessment)

Treatment Proposals

NEXT FOLLOW UP (OP):

_____

Remarks:

DATE: _____

PHYSIO NAME: _____

OT NAME: _____

Current situation of the patient
(Improvement-goals achieved, functional status, ROM-Muscle strength etc., compared to previous assessment)

Treatment Proposals

NEXT FOLLOW UP (OP):

_____

Remarks: