



M E D I C A L C L E A R A N C E F O R M

PHYSICAL ASSESSMENT FOR STANDING EQUIPMENT

Section A: Patient information			
Patient name _____	Recipient identification number _____		
Diagnosis _____			
Onset date of disability _____	Date of birth _____		
Current weight _____	Current height _____		
Section B: Physician Information			
Provider's name _____	Provider number _____		
Section C: General Physical Status			
<i>*Please circle most appropriate answer. If abnormal or progress is circled, please explain in the space provided.</i>			
Cardiopulmonary status	Normal	Abnormal	Progress
Sensation/body awareness	Normal	Abnormal	Progress
Skin status	Normal	Abnormal	Progress
Sensation status	Normal	Abnormal	Progress
Muscle strength status (Specify upper and lower strength)	Normal	Abnormal	Progress
Muscle tone status	Normal	Abnormal	Progress
ROM status (Specify upper and lower ROM)	WFL (within functional limits)	Abnormal	Progress
Standing static and dynamic balance	Normal	Abnormal	Progress
Sitting static and dynamic balance	Normal	Abnormal	Progress

