Initial Assessment For

Physio - Rehab. O.P.D. Patient

Patient's Name		**Age/Gender**	
Occupation		**UHID No.**	
Diagnosis		**Treating Physiotherapist**	
Date:		**Reg. No. of Physio. Dept.**	
Contact No. of Patient			
Ref. Doctor			

Chief Complaints

_____

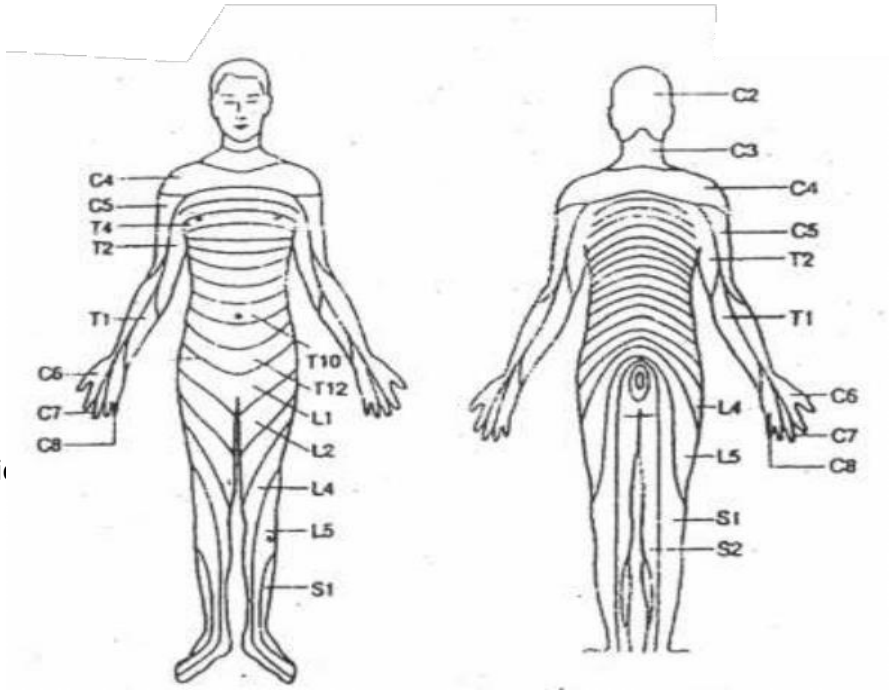
_____

History of present illness

_____

History of Pain

- Location of Pain
- Onset of Pain
- Character of Pain
- Aggravating / Relieving Positi
- Intensity



0 (No Pain) 5 (Moderate Pain)

Diabetes Mellitus	Hypertension	Tuberculosis	Surgery (if any)

Observation

• Obvious swelling ☐ Yes ☐ No
• Deformity / Contracture ☐ Yes ☐ No
• Gait and Posture

_____

• Others :

_____

Palpation

• Temperature of Skin ☐ Warm ☐ Cold
• Tenderness ☐ Yes ☐ No
• Muscle Spasm ☐ Yes ☐ No

On Examination

Joint R.O.M.

Active

Passive

Muscle Tightness ☐ Present ☐ Absent

Muscle Wasting ☐ Present ☐ Absent

Neurological Involvement

_____

_____

_____

Sensory Examination :

• Kinesthetic Sensation

_____

• Reflexes

_____

Investigation

_____

_____

_____

Clinical Diagnosis

_____

_____

_____

Treatment

_____

_____

_____

Prognosis

_____

_____

_____

Name & Signature of Physiotherapist

_____

Date _____ Time

_____

FUNCTIONAL ASSESSMENT OF PATIENTS FOR PHYSIO / REHAB.

Patient's Name _____ Age/Sex _____Regn. No. _____ IP/Physio No. _____

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				
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		
	Wheel Chair		Good	Bad		

	Orthosis right side		Good	Bad	FO	AFO	SHOE RAISE
	Orthosis left side		Good	Bad	FO	AFO	SHOE RAISE

Range of Motion/ Manual Muscle Testing

			ROM		MMT	
UPPER LIMB			**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**				

LOWER LIMB			ROM		MMT	
			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						
	Dorsiflexion	30				
	Plantar Flexion	45				
	Inversion	35				
	Eversion	15				

Name & Signature of Physiotherapist _____

Date _____ Time _____

Disclaimer