

Document ID EM/FORMAT/36/V2.0 Document Version 02 Document Category Format Issue Date 06/2026

Initial Assessment For Physio - Rehab. O.P.D. Patient

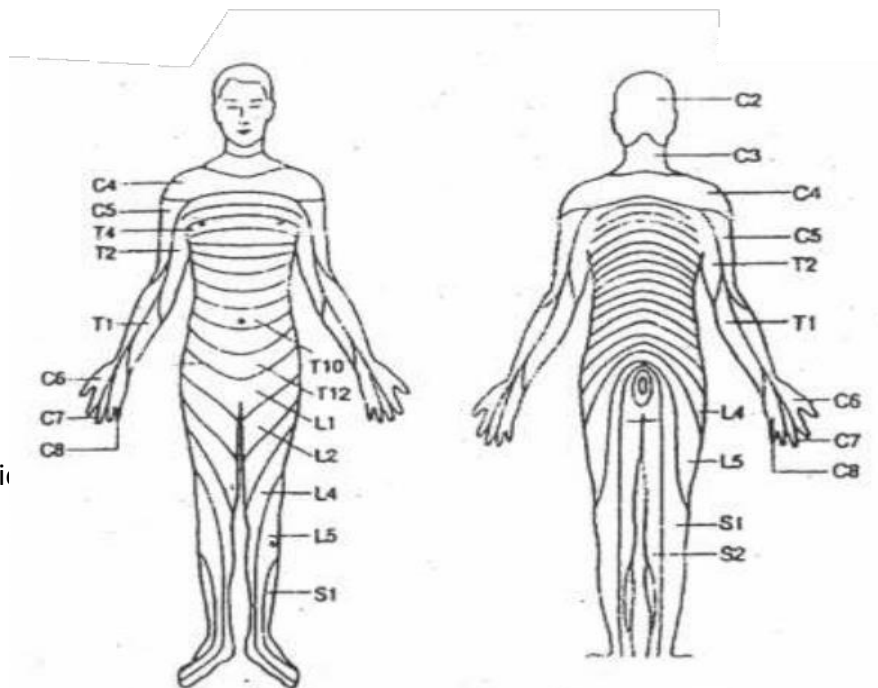
Patient's Name		Age/Gender	
Occupation		UHID No.	
Diagnosis		Treating Physiotherapist	
Date:		Reg. No. of Physio. Dept.	
Contact No. of Patient			
Ref. Doctor			

Chief Complaints

History of present illness

History of Pain

- Location of Pain
- Onset of Pain
- Character of Pain
- Aggravating / Relieving Position
- 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 _____

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