

ORTHOPEDIC PHYSIOTHERAPY EVALUATION FORM

NAME:

DATE:

Age:

Gender: M/F

IP/OP

Occupation:

Referred by:

Address:

Phone Number:

Civil Status:

Registration Number:

Diagnosis:

- Chief Complaints:

- Past Medical History:

- Personal History:

- Family History:

- Socioeconomic History:

- Symptoms History:

Side:	Site:
Onset:	Duration:
Type:	Severity:

Aggravating Factors:

Relieving Factors:

- **On Palpation**

Tenderness

D/F tissue tension and texture:

Spasm:

Type of Skin:

Scar:

Swelling:

Crepitus, Abnormal sounds:

- **On Examinations**

1. Motor Assessment

- Range of Motion (ROM)

Upper Limb

JOINT	MOVEMENT	ACTIVE RT/LT	PASSIVE RT/LT	END FEEL	LIMITATION
SHOULDER					
ELBOW					
FOREARM					
WRIST					
HANDS & FINGERS					

Lower Limb

JOINT	MOVEMENT	ACTIVE RT/LT	PASSIVE RT/LT	END FEEL	LIMITATION
HIP					
KNEE					
ANKLE					
FOOT					

SPINE

JOINT	MOVEMENT	ACTIVE	PASSIVE	END FEEL	LIMITATION
CERVICAL SPINE					
THORACIC SPINE					
LUMBAR SPINE					

▪ Manual Muscle Testing (MMT)

UPPER LIMB

Muscles	Rt.	Lt.
SHOULDER		
Flexor		
Extensor		
Abductors		
Adductors		
External Rotators		
Internal Rotators		

ELBOW		
Flexors		
Extensors		
FOREARM		
Pronators		
Supinators		
WRISTS		
Flexors		
Extensors		
Radial Deviators		
Ulnar Deviators		
HAND		
Intrinsics		
Extrinsics		

LOWER LIMB

MUSCLES	Rt.	Lt.
HIP		
Flexors		
Extensors		
Abductors		
Adductors		
External Rotators		
Internal Rotators		
KNEE		
Flexors		
Extensors		
ANKLE		
Dorsiflexors		
Plantarflexors		
FOOT		
Invertors		
Evertors		
Intrinsics		
Extrinsics		

Trunk Flexors		
Trunk Extensors		
Trunk Side Flexors		
Trunk Rotators		

- Resisted Isometrics (RI)

MUSCLES	FINDINGS
Upper Limb	
Lower Limb	

- Reflexes

	Reflex	Left	Right
SUPERFICIAL	Abdominal		
	Plantar		
DEEP	Biceps		
	Brachioradialis		
	Triceps		
	Knee		
	Ankle		

- Muscle Girth

Area	Rt.(cm.)	Lt.(cm.)
Arm		
Forearm		
Thigh		
Calf		

- Limb Length Discrepancies+++++++

Side	Rt.(cm.)	Lt.(cm.)
True		
Apparent		

2. Sensory Assessment

Location	Upper Extremity		Lower Extremity		Trunk		Comments
	Rt.	Lt	Rt.	Lt.	Rt.	Lt.	
Sensation							
Superficial							
Pain							
Temperature							
Touch							
Pressure							
Deep							
Mov. Sense							
Pos. Sense							
Vibration							
Cortical							
Tactile Localization							
2 pt. discrimination							
Stereognosis							
Barognosis							
Graphesthesia							
Texture Recognition							
Double Simultaneous Stimulation							
Dermatomes							
Myotomes							

3. Functional Assessment: (The Functional Independence Measure)

Evaluation 1: Selfcare

Item 1. Food

Item 2. Care of appearance

Item 3. Hygiene

Item 4. Dressing upper body

Item 5. Dressing lower body

Evaluation 2: Sphincter control

Item 6. Control of bladder

Item 7. Control of bowel movements

Evaluation 3: Mobility

Item 8. Bed, chair, wheel chair

Item 9. To go to the toilets

Item 10. Bath-tub, shower

Evaluation 4: Locomotion

Item 11. Go, wheel chair

Item 12. Staircases

Evaluation 5: Communication

Item 13. Auditive comprehension

Item 14. Verbal expression

Evaluation 6: Social adjustment/cooperation

Item 15. Capacity to interact and to socially communicate

Item 16. Resolution of the problems

Item 17. Memory

4. Gait Analysis

Stance Phase:	Base Width:
Swing Phase:	Cadence:
Step Length:	Other:
Stride Length:	

5. Balance

Static

Sitting (With eyes open & closed)	
Standing (With eyes open & closed)	
Tandem Standing (With eyes open & closed)	

Dynamic

Reaching Activities	
Perturbation	

6. Hand Function

Reaching	
Grasping	
Releasing	
Assisstive Devices	

7. Coordination

Non Equilibrium Tests	Rt.	Lt.	Equilibrium tests	Grade
Finger to nose			Standing: Normal Posture	
Finger opposition			Standing: Normal Posture with vision occluded	
Mass Grasp			Standing: Feet together	
Pronation/Supination			Standing on one foot	
Rebound test			Standing: Lateral trunk flexion	
Tapping (Hand)			Tandem walking	
Tapping (Foot)			Walk: Sideways	
Heel to knee			Walk: Backward	
Drawing a circle(Hand)			Walk in a circle	
Drawing a circle(Foot)			Walk on heels	
			Walk on toes	

8. Investigations

9. Special Tests

Tests	Positive	Negative

10. Problem List

<u>IMPAIREMENT</u>	<u>FUNCTIONAL LIMITATION</u>	<u>DISABILITY</u>

11. Functional Diagnosis

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12. Goals

Short Term Goals	
Long Term Goals	

13. Treatment Plan

Empty box for Treatment Plan.

14. Home Programme

Empty box for Home Programme.

Date:	Physiotherapist's Name & Signature:
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