

RAM PHYSIOTHERAPY CENTRE

Patient Info :

ASSESSMENT FORM

1. Patient Id : Date of Assessment :

2. Name : Age : Sex : M F

3. Reason for Reference : Referred by

4. Vital Sign : BP Temp Spo2 RR Others

Subjective Assessment : HISTORY

A) Present : Past :

MEDICAL K/C/O DM HT CAD THYROID IHD OSTEO HYST CHOLES CABG CA Others

B) Family / Personal : Married Smoker Alcoholic

C) Early Morning Stiffness : Yes No

D) Pain Assessment :

Onset : Traumatic Gradual Insidious Chronic Episodal

Acute Sub-acute Chronic

E) Duration : Months Years Weeks

Irritability : Continuous Intermittent Transient

Sleep Disturbance

Aggravating Factor	Relieving Factor
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F) Nature :

Muscle: Cramping Aching Throbbing

Ligament: Sharp Stabbing Pricking

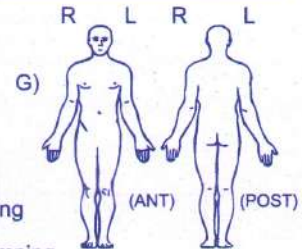
Tendon / Cap: Deep Nagging Dull Boring Cramping

Bones : Diffuse Throbbing Burning Threading

Arterioles : Referred Jumping

Visceral : Sharp Lightening Shooting

Neural : Others :



H) Pain Scale : 0 1 2 3 4 5 6 7 8 9 10

Objective Assessment :

i. On Observation

1. Body Built : Ectomorph Mesomorph Endomorph

2. Posture: Typical Handedness Layered Back

Cervical / & Thoracic Spine : FHP Chin Poke Flat Neck Mid Cervical Hinge (C4-C5)

Dowager's

Lumbar Spine : Kyphosis Scoliosis Sway Back Hyper Lordosis

Flat Back

Scapula : Elevated Tipped Downward Rotated Inferior Tipped Winging

3. Oedema : Pitting Non-pitting Temperature Skin Changes

4. Muscle Wasting: Yes cm No

5. Attitude of Limb: Wound Scars

ii. On Palpation : Warmth Crepitus Nodules Spasm

Tenderness I II III IV

iii. On Examination :

A) Limb Length : True cm Apparent cm

B) Gait : Trendelenburg Antalgic Lurching Waddling Others

IV ROM & Motor Examination :

A)

ROM	R	L	R	L	POWER

B) End Feel : ☐ Bony / Hard ☐ Soft Tissue ☐ Firm ☐ Empty

C) Sensory Examination

1) Grading :-

Dermatomes :

Joint Play Movements

2) DTR

S0	S1	S2	S3+	S4
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0	1+	2+	3+	4+	5+
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Investigation 1) ☐ X-ray ☐ MRI/CT ☐ Others Specific:

2) Functional Questionnaires

SCALE USED	SCORE	D/O/A	D/O/A	SCORE

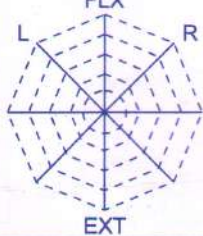
3) Deformity :

4) Resisted Isometric :

Special Test

S.No.	Name of Test	Ruled Out / In Structure

Movement Diagram :



Restriction & Compensation IA:

UCM	TRANSLATIONAL	RANGE
RESTRICTION	ARTICULAR	MYOFASCIAL

P/D:

Plan :

Problem	List Of Impairment	Clinical Solution	Parameter	Others

ANY OTHERS / COMMENTS: (Specific) :

ASSESSMENT BY

NAME :

DATE :