



2130 North Park Dr, Unit 2. Brampton, ON L6S 0C9  
Tel: Fax:

Patient: \_\_\_\_\_

D.O.Ass: \_\_\_\_\_ D.O.Acc: \_\_\_\_\_

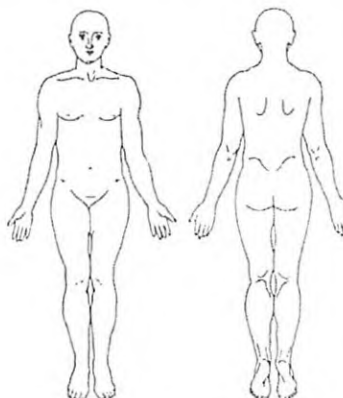
Job Description: ☐ Standing ☐ Sitting ☐ Lifting ☐ Other

Family Dr: \_\_\_\_\_

☐ Verbal consent obtained to proceed with the assessment.

**Current Hx:**

☐ Worse ☐ Same ☐ Better



**General Health:**

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> High B.P     | <input type="checkbox"/> Diabetics        | <input type="checkbox"/> Cholesterol    |
| <input type="checkbox"/> Pacemaker    | <input type="checkbox"/> Pregnancy        | <input type="checkbox"/> Metal Implants |
| <input type="checkbox"/> Recent #     | <input type="checkbox"/> Allergies        | <input type="checkbox"/> Arthritis      |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Clotting Factors | <input type="checkbox"/> Epilepsy       |
| <input type="checkbox"/> Thyroid      | <input type="checkbox"/> Cancer           | <input type="checkbox"/> Other          |

**Type of Pain:**

xxxxx- Pain

////////- Tingling

----- - Numbness

~~~~~ - Burning

ooooo - Sharp & Shooting Pain

☐ Sore

☐ Dull

☐ Cramping

**Past Hx/Previous Rx:** Yes / No

**Medications:**

**Diagnostic Tests:** Yes / No

**Date:** \_\_\_\_\_

**Recent:** ☐ X-Rays ☐ MRI ☐ US

☐ CT Scan

**Result:** \_\_\_\_\_

**Work Hx:** ☐ Working ☐ Modified hours ☐ Off

Work ☐ Not working due to accident ☐ Not working

☐ Modified duties ☐ Not working due to Pain

**Pain / Altered Sensation:**

**Onset:** Insidious / Sudden

**Duration:** Constant / Intermittent / Periodic / Occasional

**Intensity** Today: \_\_\_\_ / 10 Before: \_\_\_\_ / 10

**Pattern:** Morning / Day / Night

**(VAS):** Today: \_\_\_\_ / 10 Before: \_\_\_\_ / 10

**Difficulty in** Yes / No

**Irritability:** Mild / Mod / Severe

**ADL's:**

**Disturbed** Yes / No / Sometimes

**Sleeping** Supine / Prone / Side (R / L)

**Sleep:**

**posture:**

**Aggravated by :** ☐ All Activities ☐ Lifting

**Eased by:** ☐ Rest ☐ Medications ☐ Sitting

☐ Bending forward / Backwards ☐ Twisting

☐ Lying ☐ Standing ☐ Gel Application

☐ Overhead movts ☐ Carrying ☐ Long walking

☐ HEAT application ☐ ICE application

☐ Long Standing ☐ Climbing ☐ Running

**Able To Stay in one Position:** 15min / 20 min / 30min / 1hr

☐ Long Sitting ☐ Weight Bearing ☐ Neck movts

**Screening Questions:**

☐ Saddle Paresthesia

☐ Fever

☐ Headaches

☐ Dizziness

☐ Blackouts

☐ Bowel & Bladder

☐ Dysphagia

☐ Hx. Corticosteroids

☐ Diplopia

**EXAMINATION:**

- a. C/sp A/ROM: C/sp: Fl: \_\_\_\_\_ Ex: \_\_\_\_\_ Lt Rot: \_\_\_\_\_  
Rt Rot: \_\_\_\_\_ Rt Lat Fl: \_\_\_\_\_ Lt Lat Fl: \_\_\_\_\_
- b. Shoulder: Fl: \_\_\_\_\_ Abd: \_\_\_\_\_ ER: \_\_\_\_\_ IR: \_\_\_\_\_
- c. L/sp: Fl: \_\_\_\_\_ Ex: \_\_\_\_\_ Rot: \_\_\_\_\_
- d. Posture: FHP/ Lordosis/ Scoliosis/ Kyphosis /ASIS Shift
- e. Knee A/Rom: Fl: \_\_\_\_\_ Ex: \_\_\_\_\_
- f. Elbow A/Rom: Fl: \_\_\_\_\_ Ex: \_\_\_\_\_
- g. Ankle A/Rom: Right PF: \_\_\_\_\_ DF: \_\_\_\_\_ Inv: \_\_\_\_\_ Ev: \_\_\_\_\_  
Left PF: \_\_\_\_\_ DF: \_\_\_\_\_ Inv: \_\_\_\_\_ Ev: \_\_\_\_\_
- h. Gait: \_\_\_\_\_

**PALPATION:**

- Swelling: Mild / Moderate / Severe / Absent
- Inflammation: Warmth / Present / Absent
- Tenderness:
- Muscle Spasm:
- Stiffness: C/sp: \_\_\_\_\_ L/sp: \_\_\_\_\_ T/sp: \_\_\_\_\_ R / L Knee: \_\_\_\_\_  
R / L Shl: \_\_\_\_\_ R / L Elbow: \_\_\_\_\_ R / L Wrist: \_\_\_\_\_
- Tightness: SCM: \_\_\_\_\_ UFT: \_\_\_\_\_ MFT: \_\_\_\_\_ Quads: \_\_\_\_\_  
TA: \_\_\_\_\_ Paraspinals: \_\_\_\_\_ Hams: \_\_\_\_\_ Calf: \_\_\_\_\_ TFL: \_\_\_\_\_

**SPECIAL TEST:**

Slump Test:

SLR:

Shoulder Test:

Elbow Test:

Knee Test:

Wrist Test:

C/sp Test:

Ankle Test:

Other Test:

**Summary:**


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**Patient Goals:**

**PT Goals:** Decrease Pain, Decrease Tenderness, Decrease Stiffness, Decrease Swelling, Increase Function, Increase ROM, Increase Strength, Education, Motivation, A/ROM Ex's, Isometric Ex's.

**Treatment Plan:** 1).

- 2).
- 3).
- 4).
- 5).
- 6).
- 7).

☐ Obtained Informed Consent for Treatment

Therapist Signature:



