Physiotherapy Assessment Form

Patient Name	:	Vision Test Patient			Emirates ID	:	784-6987-5266587-7
File No	:	2	DOB	: 2020-06-17	Nationality	:	Indian
Gender	:	Female	Doctor's Name	: Ahmad Irfan	Date	:	2023-12-07

NAME:Vision Test Patient AGE :3 CONTACT NO.:971569874589

Referring Healthcare professional : Ahmad Irfan

CHIEF COMPLAIN:
s

HISTORY :
s

MEDICATIONS:
s

Mental Status: ☑Oriented ☐Disoriented ☐Impaired Cognition ☐Others

Pain Assessment Score: ◉1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

Pain Classification: ☑Acute ☐Sub Acute ☐Chronic

Recurrent: s

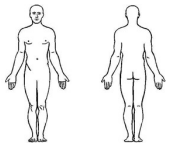
Duration of Injury : 12/15/2023 12:00:00 AM

Condition Status: ☑Getting Worse ☐Better ☐Still the same

AFFECTED BODY PARTS:s

PHYSICAL ASSESSMENT

OBSERVATION INSPECTION:s
PALPATION :s
ROM : s
MUSCLE POWER TEST :s
SPECIAL TEST:s



NEUROLOGICAL ASSESSMENT

REFLEXES:s DERMATOME:s MYOTOMEs

ADL ACTIVITIES: ☑Independent ☐dependent ☐Dependent Needs Crutche/Walker/heelchair

Physical Condition: ☑Active ☐Athlete Sedentary ☐Lifestyle Bedridden

RADIOLOGY REPORT :s

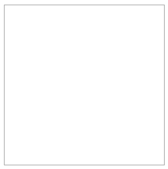
DIAGNOSIS:NA

TREATMENT PLAN

PROCEDUREâ€“ s

DIFFERENTIAL DIAGNOSIS:NA
SHORT TERM GOAL:s
LONG TERM GOALS: s
FOLLOW UP PLAN & SESSIONS :s
RECOMMENDED REFERRAL -s

Evaluated by :Ahmad Irfan

Sign here, only if all of your questions have been answered to your satisfaction	
PATIENT	DOCTOR
	
Patient Name Vision Test Patient Date 2023-12-07 09:45	Doctor Name Ahmad - Hijama (GD007) Date 2023-12-07 09:45