

## INITIAL ASSESSMENT

---

NAME:

DATE:

AREA OF INJURY:

DATE OF INJURY:

OCCUPATION:

ACTIVITIES:

### INCIDENT HISTORY

---

Chief Complaint:

MOI:

### PAIN

---

Intensity

Type

Constant/Intermittent

Numbness/Tingling

Improve/Static/Worse

Night Pain

Aggravated by:

Alleviated by:

### PREVIOUS MEDICAL HISTORY

---

Previous Injuries

Special Tests/Medications

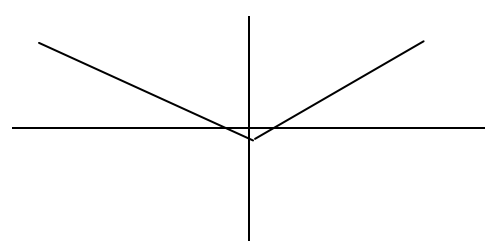
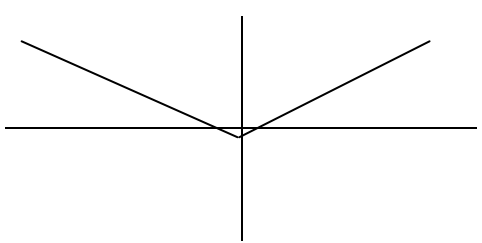
<p style="text-align: center;"><b>POSTURE</b></p> <p>R/L Handed Orthotics</p>	<p style="text-align: center;"><b>GAIT</b></p> <p><u>Squat:</u></p>
---	---

**FUNCTIONAL TESTS**

**RULE OUTS:** Wipe Test:                      TOS:                      Appleys:

**JOINT**

Movement	AROM		PROM		RROM	
	R	L	R	L	R	L



**SPECIALS:**  
Fflex:                      Kinetic:  
D.T.:

**PALPATIONS:**

**INDEX OF SUSPICION:**

**PLAN:**