



Patient Use Only

Name: _____
 Phone: _____
 D.O.B.: _____
 Physician: _____
 Job Title: _____
 Diagnosis: _____

Date of Service

Have you had any falls in the past year? Yes No
 Do you exercise? No Yes
 If yes, please explain: _____
 Do you use an assistive device (i.e. cane): _____

What percentage of your week is spent performing the following task:

Task	Do you perform these activities?		Check categories you do not feel 100% confident completing due to injury.
	No	Yes	
Walking a dog or pushing a child in a stroller	No	Yes	
Unpacking groceries	No	Yes	
Climbing stairs	No	Yes	
Carrying a child	No	Yes	
Getting in and out of car	No	Yes	
Sweeping or vacuuming	No	Yes	
Taking out the garbage	No	Yes	
Loading/unloading dishwasher, washer, dryer	No	Yes	
Dusting overhead or below knee level	No	Yes	
Cooking/Baking	No	Yes	

Clinician Use Only

Physical Therapist
 Name: _____
 Physical Therapist Assistant: _____

LE balance/functional checklist

Functional Assessment

Ambulates 20 feet in < or = to 5.5 seconds
 Pivot turns in < or = 3 seconds
 Steps over a 6" obstacle without loss of balance or change in gait speed
 Ambulates 20 feet while turning head left or right every 5 feet without deviating > 12 inches or changing gait speed
 Ambulates 20 feet while tipping head up or down every 5 feet without deviating > 12 inches or changing gait speed
 Able to stand on one leg for > or = 5 seconds (time required to don pants in standing)
 Has functional reach of 10" or more
 Ambulates 10 steps heel to toe without loss of balance

Able/Unable

Home assessment needed? Yes No
 Balance assessment needed? Yes No LE functional assessment needed? Yes No
 BPPV assessment needed? Yes No Clinic: CL FL GL KN KS PL
 Follow Up Date: Phone Fax E-mail PP RN RS TL UG WF

Comments: _____



Functional Job Demands Form

Name: _____ Referring Dr.: _____
 Phone Number: _____ Date of Injury: _____
 DOB: _____ Employer: _____
 Diagnosis: _____ Employer Contact: _____
 Job Title: _____ Employer #: _____

Briefly describe your job: _____

Work activities that are a problem? _____

What tools do you use on your job? _____

What percentage of your day is spent performing the following tasks:

Task	Frequency:	0% Nothing	1-33% Occasional	34-66% Frequent	67-100% Continuous
Standing					
Sitting					
Lift 20 to 50lbs.					
Lift 50-100 lbs.					
Lift 100+ lbs					
Carry 20 to 50lbs.					
Carry 50-100 lbs.					
Carry 100+ lbs					
Push/Pull					
Bend/Squat/Kneel					
Grasping/Pinching					
Below Shoulder Reaching					
Above Shoulder Reaching					
Balance					
Climbing					

Do you have any current work restrictions? Y N

If yes, please list: _____

Do you have any other limitations (ex: lifting restrictions from a previous injury)? Y N

If yes, please list: _____

****THERAPIST USE ONLY****

Present Work Status: (circle two) Part Time Full Time / Regular Duty Modified/Light Duty
 Off of Work? Y N Why? _____ Surgery? Y N Date of surgery? _____
 Do you know the job's physical demands to establish return to work goals? Y N
 Job description needed? Y N JDA needed? Y N Ergo consult needed? Y N
 FCE anticipated? Y N Work Hardening anticipated? Y N
 FPN anticipated date: _____ FDS anticipated date: _____
 Does this job require balancing (climbing, working at heights)? Y N
 Therapist Name: _____ Date: _____

Clinic (Please Circle): BC CL FL GL IL KN KS MA PL RS TL UG WF WKSA WKGN

Comments: _____

