



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: _____