History of Presenting Injury

1. Region
2. Date of Onset
3. Mechanism of Injury — Acute — Overuse — AoC
4. Medical Attention to date
    1. Physician / Imaging / Medications
5. Pending Consults / Orders — None

Medical History

1. Previous Injury?	Yes	No
2. Did it fully resolve?	Yes	No
3. Family Hx	Neg	Pos
4. Hx of Surgery	Neg	Pos
5. Travel	Neg	Pos
6. Weight loss	Neg	Pos

Subjective

1. Primary Complaint		
2. Location		
3. Referred pain?	Yes	No
4. Nature		
5. Frequency	Constant	Periodic
6. Intensity	Lowest	Highest
7. Time to resolve	Quick	Hours
8. Triggers		
9. Relieves		
10. Night pain	Neg	Pos
11. Red Flags?	Neg	Pos

Physical Exam

1. **Observation**
    1. Deformity / Swelling / Bruising — Normal — Abnormal
2. **Quick Tests**

1. Gait	WNL	Abnormal
2. Deep squat	Clear	Not Clear
3. Single leg	> 10s	< 10s
4. Proprioception / Balance	> 5s	< 5s

3. **Active ROM**

1. Affected Joint	WNL	BNL
2. Joint above & Below	Clear	Not Clear
3. Palpation above & below	Clear	Tender

4. **Special Tests**
    1. Specific to the area(s) of interest
    2. Used to:
        1. Clear a region
        2. Potentially diagnose pathology

5. **Neurovascular Function**
    1. Sensation — No Deficit — Deficit
    2. Power — 5/5 — Weakness
    3. Reflexes — 2+ — < 2+
    4. Color — Normal — Abnormal
    5. Swelling — Neg — Pos
    6. Warmth — Neg — Warm+
    7. Capillary Refill — <2s — >2s
    8. Pulses
        1. Radial, Brachial — Strong — Weak
        2. Dorsalis Pedis — Strong — Weak
        3. Posterior Tibial — Strong — Weak

Social History

1. Occupation — Not working — Part time — Full time — Retired.
2. Residence / Lives with — Alone — Family — Roommate.
3. Residence — Bungalow — 2S House — Apt/Condo
4. Stairs
    1. Entry and # — None — 1-3 — > 3
    2. Inside and # — None — 1-5 — > 5
    3. Elevator — No stairs
5. **Support System**
    1. Who would they call for help — Family — Friend — Other
    2. Community Services — None — AISH — Home Care
    3. Other
6. **Home equipment**
    1. Walking — None — 2WW — 4WW
    2. Bathroom — Basement — Main — Upper
    3. Bedroom — Basement — Main — Upper
    4. Shower / Tub — Tub — Walk in — Stool / Grab Bars
7. **History of Falls**
    1. How many in past 90 days
    2. Last fall
    3. Where? — Inside — Outside — Stairs
    4. Reason why? — Slip — Trip — Multitasking — Loss of Balance
    5. Able to Get up? — Yes — No
    6. Able to call for help? — Yes — No
    7. Injuries — Yes — No
    8. Fear of Falling — Yes — No
8. **Mobility PRIOR**
    1. Supine to Sit — Independent — Needs Help
    2. Sit to Stand — Independent — Needs Help
    3. Ambulation — Independent — Needs Help
    4. Stairs — Independent — Needs Help
    5. BADL — Independent — Needs Help
    6. IADL — Independent — Needs Help