United Therapy Centers
Physical Therapy Evaluation

Patient Name: ELVA TEST **Account Number: 44279**

Date: 07/31/2008 **Accident Date: 01/01/2009**

Diagnosis: lower back sprain **Occupation: basketball coach**

Relevant History: Pt. is a 30 y/o ☐male/☒female who complains of trouble bending and lifting

Relevant Medical History: ☒non-contributory

Medications: OTC PAIN MEDICATIONS

Medical Tests:

	Test	Result
☒	MRI	**no fractures or disc problems**
☒	X-Ray	**non-contributory**
☐	CT-Scan	
☐	EMG	
☐	Other	

SUBJECTIVE: Patient's chief complaint is ☒ pain at a 5/10 level in 3 MON
Pain is increased by: movement Decreased by: heat, rest

☒Weakness	☐Numbness
☐Other	

Patient also has difficulty with the following ADLs:

☐Sleeping	☒Bathing	☒Housework
☒Sitting for extended time	☐Hygiene	☒Vacuum
☒Standing for extended time	☒Hair	☒Lifting
☒Walking	☐Bending	☒Child Care
☒Running	☐Cooking	
☐Other	☐Dishes	

OBJECTIVE: Appearance:

(+/-)		
+	Spasm	
-	Asymmetry	
-	Edema	
-	Ecchymosis	
-	Wasting	
	Other	

Gait: ☒Normal Gait Pattern, ☐Decreased Stance Time on ☐Right/☐Left, ☐Decreased Stride Length on ☐Right/☐Left, ☒Circumduction on ☐right/☒left, ☐Other

Balance: good XFERS:

Palpation: Tender in: L3-L5 Spasm in: L3-L5

Other: _____

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ROM: *Cervical* Flexion 30, ext 30, Rrot 40, Lrot 40, R late flex 30, L lat flex 30
Lumbar Flexion _____, ext _____, R lat flex _____, L lat flex _____

_____ Flexion _____, ext _____, abd _____, add _____, Int rot _____, ext rot _____,plantar fl _____, dorsi fl _____, inversion _____, eversion _____, pronation _____, supination _____, radial dev _____, ulnar dev _____

_____ Flexion _____, ext _____, abd _____, add _____, Int rot_____, ext rot _____,plantar fl_____, dorsi fl _____, inversion _____, eversion _____, pronation _____, supination _____, radial dev _____, ulnar dev _____

_____ Flexion _____, ext _____, abd _____, add _____, Int rot_____, ext rot _____,plantar fl_____, dorsi fl _____, inversion _____, eversion _____, pronation _____, supination _____, radial dev _____, ulnar dev _____

Strength Deficit:

Sensation: ☒No C/O, ☐Paraesthesia, ☐Numbness:
Reflex: _____

Special Test:

+/-		+/-	
	Cervical Compression		Sitting Root Test L☒, R☐, B/L☐
	SLR L ☐, R☐, B/L☐		LaSegue L☐, R☐, B/L☒
	Sacroiliac Compression L☐,R☐, B/L ☐		Sacroiliac Distraction L☐,R☐,B/L☐
	McMurray Test L☐, R☒, B/L☐		Cruciate Draw Test L☐,R☐,B/L☐
	Ligament Stability L☐, R☐, B/L ☐		Tinel's Sign L☐,R☐, B/L☐
	Other		Other

Assessment: ☐Pain in: ☐↓ed ROM

☒↓ed Strength 30% ☐↓ed Sensation
☐Other

	STG		**LTG**
☒	Increase ROM in: by %	☐	Increase ROM in: to % of norm
☐	Increase strength in: to /5	☐	Increase strength in: to /5
☐	Decrease pain in: to /10	☒	Improve endurance in: 2 months
☒	Decrease tenderness in:	☐	Improve gait/balance:
☐	Other:	☐	Improve Ability to:

Plan: ☒Modalities PRN including (☒Heat/cold Pack,☐Infrared,☐Electric Stimulation,☐Therapeutic Ultrasound,☒Cervical Traction,☐Lumbar Traction, ☐ Whirlpool,☐Paraffin,☐Phonophoresis,☐Massage,☐Manual Therapy,☐Therapuetic Exercise to increase strength and flexibility,☒Therapeutic activities to improve functional ability,☐Patient Education,☐PNF Techniques, ☐OTHER

Physical Therapist Signature: