

CVH-504 **CONNECTICUT VALLEY HOSPITAL**  
 Rev. 5/01 **PHYSICAL THERAPY**  
**LOWER EXTREMITY EVALUATION**

[ ] General Psychiatry Division Name: \_\_\_\_\_  
 [ ] Whiting Forensic Division  
 [ ] Addiction Services Division MPI#: \_\_\_\_\_ *Print or Addressograph Imprint*

Ward/Unit \_\_\_\_\_ Date of Admission \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Treating Diagnosis/Chief Complaint: \_\_\_\_\_

History of Leg Problems - Prior Leg Surgeries: \_\_\_\_\_

Other History: \_\_\_\_\_

Anticipated Occupation Upon Discharge: \_\_\_\_\_

Hand Dominance: [ ] Left [ ] Right Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Leg Length: Measured from \_\_\_\_\_ to \_\_\_\_\_ Left \_\_\_\_\_ Right \_\_\_\_\_

Gait Deviations & Assistive Devices Used: \_\_\_\_\_

Posture: \_\_\_\_\_

ROM & Strength:	Left		Right	
	ROM	Strength	ROM	Strength
Hip Flexion				
Hip Extension				
Hip Abduction				
Hip Adduction				
Hip Internal Rotation				
Hip External Rotation				
Knee Flexion				
Knee Extension				
Patella Mobility				
Ankle Dorsiflexion				
Ankle Plantarflexion				
Ankle Inversion				
Ankle Eversion				
Toes Flexion				
Toes Extension				
Toes Abduction				
Toes Adduction				

Pain (location, type & intensity): \_\_\_\_\_

Reduces: \_\_\_\_\_ Exacerbates: \_\_\_\_\_

Sensation, Reflexes, & Proprioception: \_\_\_\_\_

\_\_\_\_\_

Endurance: \_\_\_\_\_

Palpation (soft tissue & bony) & Joint Integrity: \_\_\_\_\_

\_\_\_\_\_

Circulation/Edema (circumferential measurements): \_\_\_\_\_

\_\_\_\_\_

Special Tests: \_\_\_\_\_

\_\_\_\_\_

Assessment: \_\_\_\_\_

\_\_\_\_\_

Recommendations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Goals of Therapy: ☐ Independent Exercise Program

☐ Normalize Gait Pattern to permit \_\_\_\_\_

☐ Decrease Pain to \_\_\_\_\_ level to permit \_\_\_\_\_

☐ Other \_\_\_\_\_

Treatment: ☐ Exercise Program

☐ Modalities

☐ Gait Training

☐ Orthotics/Assistive Devices \_\_\_\_\_

☐ Other \_\_\_\_\_

Frequency of Treatment: \_\_\_\_\_

Assessment and Treatment Plan Discussed with Patient? ☐ Yes ☐ No (Reason) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature/Title of Therapist

\_\_\_\_\_  
Date