CVH-505 **CONNECTICUT VALLEY HOSPITAL**

Rev. 5/01 **PHYSICAL THERAPY - GAIT ANALYSIS – FULL BODY**

[ ] General Psychiatry Division Name _____

[ ] Whiting Forensic Division

[ ] Addiction Services Division MPI# _____ *Print or Addressograph Imprint*

Instructions: 1. Perform gait analysis without bracing or support; use least possible manual support.
2. To indicate a sustained posture, place a (P) in the appropriate box.
3. Place a check (**X**) in appropriate box; if unilateral involvement, use R or L instead of check.

		SWING			STANCE					STEP (Relationship of heel to opposite foot)
		Initial Swing	Mid-Swing	Term Swing	Initial Contact	Loading Response	Mid-Stance	Term Stance	Pre-Swing	
TRUNK	Backward Lean									
	Forward Lean									
	Lateral Lean (R or L)									
	Rotates Back									
	Rotates Forward									
PELVIS	Hikes									
	Symphysis Up									
	Symphysis Down									
	Lacks Forward Rotation									
	Lacks Backward Rotation									
	Excess Forward Rotation									STANCE RATIO:
	Excess Backward Rotation									Unequal
	Ipsilateral Drop									
	Contralateral Drop									
HIP	Flexion: Limited									HEAD CONTROL:
	Absent									Extraneous Motion
	Excessive									Abnormal Posture
	Inadequate Extension									
	Past Retracts									
	External Rotation									ARM SWING:
	Internal Rotation									Diminished
	Abduction									Absent
	Adduction									Abnormal Posture
	Circumduction									
KNEE	Flexion: Limited									
	Absent									LIST MAJOR
	Excessive									PROBLEMS AND
	Inadequate Extension									CAUSE(S):
	Wobbles									SWING PHASE:
	Hyperextends									
	Extension Thrust									
	Valgus									
	Varus									
	Excess Contral. Flexion									
ANKLE & FOOT	Excess Plantar Flexion									
	Excess Dorsiflexion									
	Toes First									
	Foot Flat									
	Foot Slap									
	Varus									
	Valgus									STANCE PHASE:
	Wobbles									
	Heel Off									
	Roll Off: Limited									
	none									
	Contralateral Vaulting									
TOES	Up									
	Down									
	Drag									
	Clawed									

_____ _____

Signature/Title of Therapist/ Printed Name and Title Date