Day Rehabilitation Unit

Initial Assessment

Calvary Health Care

(Please complete or affix Addressograph Label here)

MRN_____ DOB_____

Surname_____

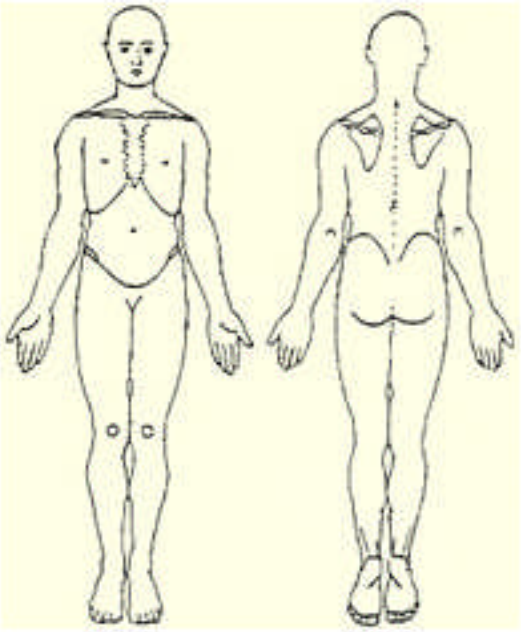
Given Names_____

Date:

HPI _____

_____

Body Chart



Screening:

VBI ☐

SC ☐

CE ☐

Other ☐ _____

Visual Analog Scale (VAS)

☺ 10cm scale ☹

No pain Pain as bad as it could be

Medications: _____

_____

_____

PMHx _____

_____

_____

_____

SHx _____

_____

Services _____

Stairs Front _____ Rail _____

Internal _____ Rail _____

Rear _____ Rail _____

PREMORBID STATUS

Aid _____ Ex Tol _____

Comm mob _____

Stairs _____

Falls _____

CALVARY HEALTH CARE SYDNEY
DO NOT WRITE

PHYSIOTHERAPY – Initial Assessment Form

SE _____

Pain _____

OE _____

STS _____

Mobility _____

Gait _____

Stairs _____

3MWT _____ Timed up and go _____

Berg balance test _____ Other _____

Joint Range of Motion _____

_____

MMSE/Rudas _____

Special Tests Height: Weight: BMI: _____

_____

_____

_____

_____

_____

Treatment _____

_____

_____

Plan _____

_____

Short Term Goals	**Time Frame**

Risk assessment for DRU bus travel: (please circle) HIGH MEDIUM LOW

Comment on level and type of help required on the bus for applicable patients: _____

_____

Physiotherapist: _____

Signature: _____

Date: _____

- Rights and Responsibilities Brochure given to patient YES

CALVARY HEALTH CARE SYDNEY
DO NOT WRITE