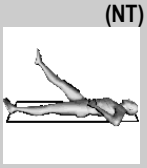
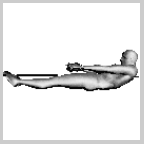
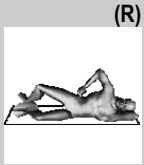
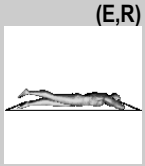
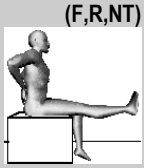
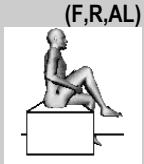
START POSITION ** key tests	TEST ITEM dd/mm/yy of test	IDEALS Optimal ✓ Impaired ✘	COMMON FAULTS Normal ✓ Faulty / Impaired ✘

SUPINE 	#1. Hip Flexor Length ___/___/___ Pass ❑ Fail ❑ ___/___/___ Pass ❑ Fail ❑	❑ Extended thigh on table ❑ Lumbar spine in normal lordosis ❑ Femur in midline without hip rotation or abduction ❑ Knee flexion at 80° but < 90° ❑ No lateral tibial rotation ❑ No tibial abduction ❑ Hip extended 10°	❑ TFL – ITB – more hip extension when the hip is abducted or in MR ; KF @ 80° ❑ Rectus Femoris – greater hip extension when the knee is passively extended and lumbar spine remains flat, femur abducted ❑ Iliopsoas – limited hip extension with the lumbar spine flat that is not attributed to TFL/ITB or rectus femoris shortness ❑ Lumbar spine flat but⇧ HExt - AFGS? ❑ Pelvic rotation / anterior tilt ❑ Lumbar hyperextension / rotation ❑ Tibial lateral rotation / abduction	L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑
(E,F,R) 	#2. Single knee to chest ** ___/___/___ Pass ❑ Fail ❑ ___/___/___ Pass ❑ Fail ❑	❑ Knee to chest - ROM is about 110 - 120º ❑ Neutral hip rotation ❑ Sacrum on plinth ❑ Lumbar spine flattens and contralateral hip extends slightly	❑ Unable to achieve 110-120° of hip flexion and sacrum lifts off bed (CRF - pelvis rotates >1/2") ❑ Extension sign - symptoms increase with *initiation* of hip & knee flexion - ⇧ lordosis ❑ Rotation sign - ASIS's rotate >1/2" with LE movements or pain increases ❑ Flexion sign - usually no pain with test	L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑
(R) 	#3. Hip lateral rotation & abduction with HF & KF & foot on plinth, in supine (BKFO/I) ** ___/___/___ Pass ❑ Fail ❑ ___/___/___ Pass ❑ Fail ❑	❑ LE falls out & in freely, without associated pelvic rotation. Hip abduction is 50-60º. Hip adduction is 10º ❑ PBU readings remain @>40 but <50mmHg after transversus abdominis is recruited.	❑ Patient is unable to dissociate movement in hip from lumbar spine - i.e. leg in or out associated with the DSM of lumbar rotation. ❑ Short adductors - <50º of hip abduction + "pulling" reported along inner thigh ❑ Structural hip joint issues ❑ Fallout to approx. 50% of available range THEN pelvic/lumbar rotation occurs	L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑
(NT) 	#4. Straight Leg Raise ___/___/___ Pass ❑ Fail ❑ ___/___/___ Pass ❑ Fail ❑	❑ IAR for hip should be the same for active & passive SLR. ❑ No femoral rotation associated with the active SLR	❑ The GT moves anteriorly & superiorly during *active* SLR. ❑ During *passive* SLR, GT remains in constant position but IAR may need inguinal crease pressure to maintain pain free movement. With pressure, active SLR may give anterior hip pain but will abolish pain on passive SLR ❑ Excessive MR of femur when hip flexes	L❑ R❑ L❑ R❑ L❑ R❑
	#5. Upper abdominal strength ___/___/___ Pass ❑ Fail ❑ ___/___/___ Pass ❑ Fail ❑	❑ 100% = ability to flex spine to limit of spinal flexibility & hold it flexed whilst coming to a sitting position, arms overhead. ❑ 80% = FROM, arms across the chest, and can hold limit of flexibility ❑ 60% = FROM, forearms extended forward, can hold limit of flexibility ❑ 50% = FROM, arms extended but UNABLE to hold ⇧ **Tick boxes for abdominal test as pass or fail - min. 12 reps per leg** ⇩		P❑ F❑ P❑ F❑ P❑ F❑ P❑ F❑
	#6. Lower abdominal strength ___/___/___ Pass ❑ Fail ❑ ___/___/___ Pass ❑ Fail ❑	❑ 0.3 = lift one foot, other foot remains on floor ❑ 0.4 = hold one knee to chest (max.) and lift the other foot ❑ 0.5 = lightly hold one knee toward chest and lift other foot ❑ 1.0A = hip flexed > 90º and lift the other foot ❑ 1.0B = hip flexed @ 90º and lift the other foot ❑ 2.0 = one hip flexed @ 90º , lift & slide other foot to extend hip & knee ❑ 3.0 = one hip flexed @ 90º, lift & extend hip & knee without foot touching floor ❑ 4.0 = slide both feet along floor into extension and return to crook lying ❑ 5.0 = lift both feet off floor, hip flexed to 90º, extend hip & knees, touch floor and return to crook lying		P❑ F❑ P❑ F❑ P❑ F❑ P❑ F❑ P❑ F❑ P❑ F❑ P❑ F❑ P❑ F❑ P❑ F❑
(E) 	#7. Shoulder flexion ** ___/___/___ Pass ❑ Fail ❑ ___/___/___ Pass ❑ Fail ❑	❑ 180° of shoulder flexion/elevation ❑ Hands & elbows on bed ❑ Infrasternal angle @ 90° ❑ ASIS< >PSIS perpendicular to plinth ❑ Inferior angle of scapula @ mid-axillary line	❑ Hyperlordosis ❑ Anterior pelvic tilt ❑ Inadequate shoulder flexion ❑ Depressed sternum ❑ Inability to take deep breath ❑ Infrasternal angle & rib shape altered	L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑

START POSITION ** key tests	TEST ITEM dd/mm/yy of test	IDEALS Optimal ✓ Impaired ✘	COMMON FAULTS Normal ✓ Faulty / Impaired ✘	
SIDE LYING (R) 	#8. Hip abduction and lateral rotation ** ___/___/___ Pass ❑ Fail ❑ ___/___/___ Pass ❑ Fail ❑	❑ Can move hip joint to end of range abduction without CRF elsewhere (against resistance) ❑ Can hold LE in abducted and laterally rotated (against resistance)	❑ Unable to hold in max. abduction / LR against resistance ❑ Gives at end of range then holds position ❑ Weak through range ❑ Hip MR with abduction ❑ Hip joint flexes with abduction ❑ Pelvic rotation occurs with abduction/LR ❑ Lateral pelvic tilt (cephalad) - ipsilateral ❑ Lateral pelvic tilt with adduction phase	L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑
(R,NT) 	#9. Hip adduction in the sidelying position ** ___/___/___ Pass ❑ Fail ❑ ___/___/___ Pass ❑ Fail ❑	❑ Can achieve position - pelvis neutral ❑ Can achieve 10° adduction ❑ Hip joint in = 10° HExt & LR ❑ Knee joint straight (not hyperextension)	❑ Hip unable to adduct to 10° ❑ Needs to perform HF & KF to achieve the LR & adduction position (test leg) ❑ Femur medially rotates when adducting ❑ Lateral pelvic tilt when adducting ❑ Hip joint adducts excessively >10° and glides laterally or medially rotates as the hip is adducted ❑ Pelvis tilts laterally as the hip is adducted	L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑
PRONE (E,R,NT) 	#10. Knee Flexion ** ___/___/___ Pass ❑ Fail ❑ ___/___/___ Pass ❑ Fail ❑	❑ Can take maximum resistance @ 80° KF ❑ 120° KF without pelvic tilt or rotation	❑ Anterior pelvic tilt/HF during KF ❑ Limited KF ❑ Pelvic rotation during KF ❑ Lateral tibial rotation during KF ❑ Asymmetrical pull of med. vs lat. hams ❑ Inability to relax hamstrings with release of KF at 80°	L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑
(R) 	#11. Hip rotation ** ___/___/___ Pass ❑ Fail ❑ ___/___/___ Pass ❑ Fail ❑	❑ 35° of MR without pelvic rotation ❑ 35° of LR without pelvic rotation	❑ < 35° of MR ❑ Excessive MR > 35° (consider anteversion) ❑ Range of MR is 10° > than range of LR ❑ Range of MR is 10° < than LR ❑ Tibia laterally glides on femur ❑ < 35 of LR ❑ Anterior pelvic tilt/ hip flexion during LR (TFL / ITB shortness) ❑ Pelvic rotation with LR ❑ GT moves anterolaterally during LR making a wider arc of movement than normal ❑ Excessive LR > 35° (consider retroversion) ❑ Range of LR is 10° > than MR ❑ Range of LR is < 10°than MR	L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑
(E,R) 	#12. Hip extension with knee extended ___/___/___ Pass ❑ Fail ❑ ___/___/___ Pass ❑ Fail ❑	❑ In KExt - 10° HExt achieved but initiated & maintained by gluteus maximus. ❑ Hamstrings should not dominate ❑ No CRF @ lumbar spine	❑ Anterior pelvic tilt/hip flexion/lumbar extension during hip extension ❑ Pelvic rotation during hip extension ❑ Inability to extend hip 10° ❑ In 10° of hip extension, power not 5/5 ❑ Lumbar > Hip extension ❑ Anterior femoral head glide/ GT ❑ Hamstrings > gluteal activity (delayed)	L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑
SITTING (F,R,NT) 	#13. Knee extension and ankle dorsiflexion ___/___/___ Pass ❑ Fail ❑ ___/___/___ Pass ❑ Fail ❑	❑ Erect lumbar spine ❑ Pelvis neutral ❑ HF @ 90° ❑ Knee extension to 80° with 10° of DF in STJ neutral ❑ Lumbar spine does not rotate	❑ Unable to achieve 80°of knee extension with pelvis neutral ❑ Excessive MR of femur during knee extension (TFL dominance) ❑ Unable to achieve 10° of dorsiflexion ❑ Ankle DF occurs via ED/EHL/peroneii	L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑
(F,R,AL) 	#14. Hip flexion with knee flexed to 90° ___/___/___ Pass ❑ Fail ❑ ___/___/___ Pass ❑ Fail ❑	❑ Able to maintain 120° hip flexion against resistance ❑ Lumbar spine neutral ❑ Pelvis in neutral ❑ Pushing fists into bed may be a clue to axial loading	❑ Cannot take resistance at inner range but IS able after 10-15° of hip extension occurs ❑ Cannot achieve 110° of hip flexion ❑ Able to achieve 110° of hip flexion but not able to take resistance ❑ Lumbar > hips - posterior pelvic tilt?	L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑

Signature of physical therapist:_____

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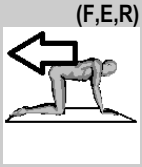
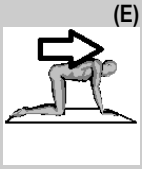
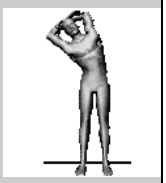
QUADRUPED (F,E,R) 	#15. Quadruped rocking back to heels ** ___/___/___ Pass ❑ Fail ❑ ___/___/___ Pass ❑ Fail ❑	❑ Thoracic spine level ❑ Scapulae flat to thorax ❑ Lumbar spine flat/level ❑ Hip joint rotation occurs without lumbar movement ❑ Instep on plinth ❑ *Lumbar = Hips* - Lumbar spine flexion begins *only* when hips are flexed 120°	❑ *Lumbar < Hip* - Lumbar spine flexion begins *after* 120° hip flexion ❑ *Lumbar > Hip* - Lumbar spine flexion begins *before* 50% of range into hip flexion ❑ Pelvic rotation towards the L or R ❑ Lateral pelvic tilt ❑ Scoliosis + rib hump ❑ Lumbar rotation (paraspinal prominence) ❑ Femur laterally rotates as patient rocks backwards	Y❑ N❑ Y❑ N❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑
(E) 	#16. Rocking forwards ** ___/___/___ Pass ❑ Fail ❑ ___/___/___ Pass ❑ Fail ❑	❑ Lumbar spine maintains normal lordosis ❑ Cervical lordosis does not increase ❑ Scapulae remain flat on the thorax ❑ Kyphosis does not increase	❑ Lumbar spine extension observed ❑ High lumbar ❑ Low lumbar ❑ Pseudo winging ❑ Increased cervical extension ❑ Stiff / short forearm flexors	Y❑ N❑ Y❑ N❑ Y❑ N❑ L❑ R❑ L❑ R❑ L❑ R❑
(R) 	#17. Arm lift ** ___/___/___ Pass ❑ Fail ❑ ___/___/___ Pass ❑ Fail ❑	❑ Lumbar spine maintains normal lordosis ❑ Cervical lordosis does not increase ❑ Scapulae remain flat on the thorax ❑ Kyphosis does not increase	❑ Lumbar rotation when in 3-point support ❑ Unable to get arm to 180° ❑ Hyperlordosis ❑ Increased cervical lordosis ❑ Scapula winging ❑ Cervical spine side flexion	L > R ❑ R > L ❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑
STANDING (F,NT) 	#18. Forward bending ___/___/___ Pass ❑ Fail ❑ ___/___/___ Pass ❑ Fail ❑	❑ Even distribution & flow of movement throughout the spine as forward curl is performed; at the end… ❑ …Sacrum - 10 - 20° above horizontal ❑ Hip flexion >70°	❑ Body shifts posteriorly >5 inches ❑ Hip flexion <70° ❑ Hip flexion >95° • *Lumbar = Hip* • *Lumbar > Hip* • *Lumbar < Hip* • *Lumbar = Thoracic* • *Lumbar > Thoracic* • *Lumbar < Thoracic*	L❑ R❑ L❑ R❑ L❑ R❑
(F,NT) 	#19. Forward bending with hip flexion only ___/___/___ Pass ❑ Fail ❑ ___/___/___ Pass ❑ Fail ❑	❑ 'Waiters Bow' – client is able to dissociate movement between hip & lumbar spine ❑ 50º hip flexion achieved – lumbar spine in neutral	❑ Lumbar > Hips – lumbar spine flexes *before* 50º hip flexion achieved ❑ Requires hands on raised surface to perform forward flexion with less/no pain ❑ Pain - location _____ ❑ Actual HF achieved? _____°	
(R) 	#20. Side bending ___/___/___ Pass ❑ Fail ❑ ___/___/___ Pass ❑ Fail ❑	❑ Normal = symmetrical curve throughout lumbar spine	❑ Apex of curve is at one point either low or high lumbar ❑ Stiff = limited motion to opposite side of stiffness ❑ Short = PT fixes pelvis; side flexion markedly limited – kinesiological norm not achieved ❑ Hands placed on last rib - SF is now less painful / pain free ❑ Rotation evident before SF or during motion …comments?	L❑ R❑ L❑ R❑ L❑ R❑ L❑ R❑ L > R ❑ R > L ❑

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ACTIVITIES OF DAILY LIVING	#21. Functional Activities	Comments… * Detail FIDM – Frequency, Intensity, Duration and Mode of workplace activities AND sports etc.	
	• *Static standing faults* ❑ Normal ❑ Faulty		
	• *Static sitting faults* ❑ Normal ❑ Faulty		
	• *Stair climbing* ❑ Normal ❑ Faulty ❑	Ascending	Descending
	• *Gait / Running* ❑ Normal ❑ Faulty		
	• *Supine to sit* ❑ Normal ❑ Faulty		
	• *Sit to stand* ❑ Normal ❑ Faulty		
	• *Sleeping position* ❑ Normal ❑ Faulty		
	• *Working position* ❑ Normal ❑ Faulty	Habitual user VDU / DSE? Y ❑ N ❑ Risk assessments completed? Y ❑ N ❑ Workplace assessment necessary? Y ❑ N ❑ Tools to use: REBA ❑ RULA ❑ EWA ❑ NIOSH ❑ Other _____	

Frequency of flexion symptoms from history?	○○○○○○○○○○○○	Flexion signs?	○○○○○○○○○○○○○○○
Frequency of extension symptoms from history?	○○○○○○○○○○○○	Extension signs?	○○○○○○○○○○○○○○○
Frequency of rotation symptoms from history?	○○○○○○○○○○○○	Rotation signs?	○○○○○○○○○○○○○○○

Primary Diagnosis: _____

Secondary Diagnosis: _____

Treatment prescribed @ first visit_____

_____

Prognostic factors influencing recovery _____
Outcome Measures used:

Signature of physical therapist:_____