Guidelines for the Completion of the Extremity Assessment Forms (June 2020)

History: Page One **Patient responses are recorded but supplemented by the clinician as appropriate**	
Referral:	Circle the appropriate. May record date of follow-up appointment.
Postures / Stresses:	**Work: Mechanical demands**: Record work activities and indicate frequency of activity, e.g. 30% sitting, 30% standing, 40% on the move. Other types of stresses can also be noted e.g. pressure from deadlines **Leisure: Activities:** Record leisure or hobby activities and indicate frequency of activity, e.g. 75% sitting, 25% bending or could say walking 3x week 40 mins, gardening 3hours/week for example. Can note activity level in general e.g. 'sedentary' or 'very active'.
Functional Limitation from Present Episode:	Ask patient about specific activities that they are unable to perform or have difficulty performing because of current symptoms.
Outcome / Screening score:	Record the specific outcome measure or screening tool being used, and the score.
NPRS Score:	Ask the patient the intensity of their pain. Can use a pain range, or use the average intensity of pain.
Body Chart:	Used to record "all symptoms the patient has experienced this episode". All symptoms may not still be present.
Handedness – Right / Left:	On Upper Extremities Chart only. Circle dominant hand.
Present Symptoms:	Record here the location/type of symptoms that are still concerning the patient. May differ from the body chart as not all symptoms may still be present.
Present Since:	Usually given in weeks or days. Can write a specific date if known or if needed for legal reasons.
Improving / Unchanging / Worsening:	Circle as appropriate, and ask patient how, or in what way, if they say they are improving or worsening.
Commenced as a Result of:	If appropriate describe mechanism of injury, e.g. lifting and twisting, MVA, injury playing sport. Or circle 'No Apparent Reason'.
Symptoms at Onset:	Circle where symptoms started, and record the timeframe of onset of associated pains.
Spinal History:	Screening for a spinal component, and can be correlated with the Body Chart and the following 2 questions.
Paraesthesia:	Relevant to the patient's history and pain location?

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Cough / sneeze:	Circle if coughing or sneezing reproduces the patient's symptoms.
Constant / Intermittent:	Circle as appropriate. Qualify the site where required.
Worse / Better Section:	Recording *Circle* for always – if not clarified this means immediate pain response. If relates to time need to clarify outside the circle with e.g. 10 minutes, prolonged. *Line under* – sometimes. *Oblique line through* – no effect. Put a '?' above activity if patient still unsure even after further questions, rather than leave blank. If two unrelated areas of pain, may need to indicate if dealing with different pain sites for each activity. Use text for Other options
Continued Use:	As above with circle, or line under for sometimes.
Disturbed Sleep:	If "always" circle Yes, "sometimes" underline Yes. "Not affected" circle No. If was previously circle Yes, but write "previously". Used for likely mechanical pain, e.g. pain turning in bed or pain related to being in a position.
Pain at Rest:	Circle as appropriate. And qualify the site where required.
Other Questions:	Circle as appropriate and write clarifications if required.
Previous History:	Write if episodic, document previous location of symptoms, length of previous episodes, severity of episodes, and if symptom free between episodes.
Previous Treatments:	Write what treatments they have had for this episode and, if appropriate what treatments/interventions they have had for previous episodes. May indicate what has helped if appropriate.
Specific Questions (related to Health, Medication, Imaging etc.)	Circle appropriate answers and write any clarifications on the lines provided.
Patient Goals / Expectations	Note what the patient's goals and expectations are.

Physical Examination: Page Two	
It is not essential to perform all components of the physical examination with every patient. If any section is not performed an oblique line is drawn through it. **NB: ALWAYS compare limbs wherever possible during the Physical Examination**	
Postural Observation:	Circle appropriate response.
Change of Posture:	Circle response and indicate which pain changes and to which posture change, if appropriate.

Physical Examination: Page Two	
Other Observations:	Record any significant musculoskeletal differences, e.g. wasting, swelling, redness etc.
Neurological Examination:	Circle NA for not applicable for this patient. Record as Normal if there is no deficit. Qualify which deficit in each section, recorded if abnormal, e.g. decreased S1 reflex. Can add Babinski / Clonus to reflexes if required.
Baselines:	Pain or functional activity. "Is there one thing you can do which always brings on, or increases, your pain?" Could be walking, squatting, steps etc. for lower limb, or reaching, throwing, dressing etc. for upper limb.
Movement Loss: **(Circle Relevant Body Site)**	Place a tick in the appropriate box. Maj/Mod/Min/Nil Can also record as a tick in the "pain" box, if patient is reporting pain limits the movement, indicate location of the pain.
Passive Movements:	Note the symptoms and range for the relevant movement being tested. Always test for end range.
Resisted Test Response:	Note direction tested and if pain or weakness elicited.
Other Tests:	State which and the response achieved.
SPINE:	
Movement Loss:	State direction and extent of loss.
Effect of Repeated Movements:	State direction and the symptomatic and mechanical response.
Effect of Static spine positioning:	State position used and symptomatic response.
Spine Testing:	Circle the position performed in and record with standard "After" words.
Baseline Symptoms	State pre-testing baseline symptoms.
Repeated Movement Testing:	Indicate the order performed by numbering if order is different to that written Useful to record the number of repetitions performed to gain the response. **Symptomatic response** - Use standard terms only. Monitor and describe effect on most distal symptoms. **Mechanical response**. Indicate which movement has been affected by the change if it is different to the one being tested, and if strength or functional test has changed.
Effect of Static Positioning:	Circle the position performed in and record with standard "After" words.
Provisional Classification:	Circle whether extremity or spinal problem. Circle the classification, Derangement, (name which joint) Dysfunction (indicate type and direction) or OTHER (name subgroup).

Physical Examination: Page Two	
Potential Drivers of Pain and / or Disability:	Circle any potential drivers of pain and disability and note details on the line below.
Principle of Management:	**Education** - Record specifics, e.g. posture change, avoidance of provocative movements. Record equipment provided. **Exercise Type -** Document the specific exercises provided to the patient. e.g. RFIL, and note **Frequency** Document any other exercises or interventions given. **Management Goals** - Indicate what you expect to change by next visit and things you wish to reassess at Follow-ups. Short and Long term goals can be recorded also.