THE McKENZIE INSTITUTE
LOWER EXTREMITIES ASSESSMENT

Date _____

Name _____ Sex M / F

Address _____

Telephone _____

Date of Birth _____ Age _____

Referral: *GP / Orth / Self / Other* _____

Work: Mechanical stresses _____

_____

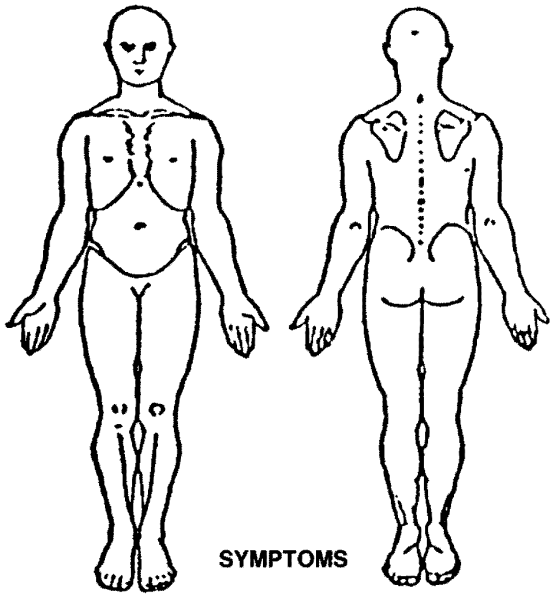
Leisure: Mechanical stresses _____

Functional disability from present episode _____

_____

Functional disability score _____

VAS Score (0-10) _____



HISTORY

Present symptoms _____

Present since _____ *Improving / Unchanging / Worsening*

Commenced as a result of _____ *Or No Apparent Reason*

Symptoms at onset _____ Paraesthesia: *Yes / No*

Spinal history _____ *Cough / Sneeze +ve / -ve*

Constant symptoms: _____ Intermittent Symptoms: _____

Worse *bending sitting / rising / first few steps standing walking stairs squatting / kneeling*
am / as the day progresses / pm when still / on the move Sleeping: *prone / sup / side R / L*
Other _____

Better *bending sitting standing walking stairs squatting / kneeling*
am / as the day progresses / pm when still / on the move Sleeping: *prone / sup / side R / L*
other _____

Continued use makes the pain: *Better Worse No Effect* Disturbed night *Yes / No*

Pain at rest *Yes / No* Site: *Back / Hip / Knee / Ankle / Foot*

Other Questions: *Swelling Clicking / Locking Giving Way / Falling*

Previous episodes _____

Previous treatments _____

General health: *Good / Fair / Poor* _____

Medications: *Nil / NSAIDS / Analg / Steroids / Anticoag / Other* _____

Imaging: *Yes / No* _____

Recent or major surgery: *Yes / No* _____ Night pain: *Yes / No* _____

Accidents: *Yes / No* _____ Unexplained weight loss: *Yes / No*

Summary *Acute / Sub-acute / Chronic* *Trauma / Insidious Onset*

Sites for physical examination *Back / Hip / Knee / Ankle / Foot* *Other*: _____

EXAMINATION

POSTURAL OBSERVATION

Sitting *Good / Fair / Poor* Correction of Posture: *Better / Worse / No Effect / NA* Standing: *Good / Fair / Poor*

Other observations: _____

NEUROLOGICAL: **NA / Motor / Sensory / Reflexes / Dural** _____

BASELINES (pain or functional activity): _____

EXTREMITIES ***Hip / Knee / Ankle / Foot***

MOVEMENT LOSS	Maj	Mod	Min	Nil	Pain
Flexion					
Extension					
Dorsi Flexion					
Plantar Flexion					

	Maj	Mod	Min	Nil	Pain
Adduction / Inversion					
Abduction / Eversion					
Internal Rotation					
External Rotation					

Passive Movement (+/- over pressure) (note symptoms and range): _____	**PDM**	**ERP**

Resisted Test Response (pain) _____

Other Tests _____

SPINE

Movement Loss _____

Effect of repeated movements _____

Effect of static positioning _____

Spine testing *Not relevant / Relevant / Secondary problem* _____

Baseline Symptoms _____

Repeated Tests	**Symptom Response**		**Mechanical Response**	
Active/Passive movement, resisted test, functional test	**During –** Produce, Abolish, Increase, Decrease, NE	**After –** Better, Worse, NB, NW, NE	**Effect –** ↑ or ↓ ROM, strength or key functional test	No Effect
Effect of static positioning				

PROVISIONAL CLASSIFICATION **Extremities** **Spine**

Dysfunction – Articular _____ Contractile _____

Derangement _____ Postural _____

OTHER _____

PRINCIPLE OF MANAGEMENT

Education _____ Equipment Provided _____

Exercise and Dosage _____

Barriers to recovery _____

Treatment Goals _____