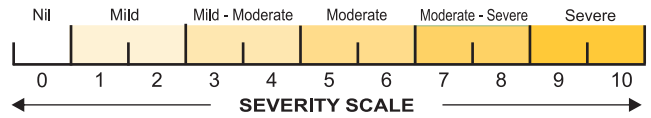


Physical and Psychological Disability.

Please complete and bring with you to the examination.



PERSONAL

ID INSTRUCTION Date: / / Time: Start Finish

Name: Date of Birth: Age: Place:

Email: Telephone: Mobile:

MEDICAL

Falls Stumbles Where?

Illnesses: <input type="checkbox"/>				Medication: <input type="checkbox"/>
1 <input type="text"/>				1 <input type="text"/>
2 <input type="text"/>				2 <input type="text"/>
3 <input type="text"/>				3 <input type="text"/>
4 <input type="text"/>				4 <input type="text"/>
5 <input type="text"/>				5 <input type="text"/>
6 <input type="text"/>				6 <input type="text"/>
Fractures <input type="checkbox"/>	Admission <input type="checkbox"/>	Operations <input type="checkbox"/>	Specialist <input type="checkbox"/>	7 <input type="text"/>
				8 <input type="text"/>
Camera <input type="checkbox"/>	CT / MRI <input type="checkbox"/>	XRAY <input type="checkbox"/>	Scan <input type="checkbox"/>	9 <input type="text"/>
Physio <input type="checkbox"/>	Podiatry <input type="checkbox"/>	Steroid Injection <input type="checkbox"/>	Acupuncture <input type="checkbox"/>	Over the counter <input type="checkbox"/>

OTHER SYMPTOMS *Circle where appropriate.*

Balance / Tinnitus / Hearing / Headaches / Fatigue / Blurred vision / Chest Pain / Short of breath / Palpitations
Sweats / Wheeze / Cough / Abdo Swelling / Vomiting / Acid / Appetite / Choking / Weight change / Dizzy

THINKING

Stress	Behaviour	Mood swings	Irritability	Low Mood	Loss of Interest	Enjoyment
Tiredness	Tearful	Worries	Fears	Panic attacks	Obsessions	Self esteem
Concentration	Forgetful	Train of thought	Speech	Confused	Slowed	Restless
On Edge	Agitated	Distracted	Rambling	Drowsy	Unpredictable	Addictions
Hallucinations	Compulsions	Guilt	Paranoia	Self harm	Nutrition	Wandering
Personal Hygiene	Dangerous Behaviour	Abnormal Thoughts	Violent-Property-People			

TYPICAL DAY

Bed / Sofa from : to : wakes times a night

Contenance: Bladder / Bowels / Pass urine at night

Self Care? Lift a Cup Eat Take Medication Toilet Make a Snack Dress Bath

Main Carer	Dress / Shoes / Socks	Finance / Paperwork	Shopping	Bath / Shower <input type="checkbox"/>
	Feed / Hair / Face	Toilet / Soiling / Night Care	Driving	Housework <input type="checkbox"/>

Skills? Write Drive Text Computer Swim Cycle Run

Housework Wash up Iron Cook DIY Vacuum Wash clothes Garden

Shopping Lists Walk to Shops Find Items Pack Bags Put Away

Pastimes? Read TV Music Games Hobbies

Social Life? Shop Meals out Visit Friends Family Cinema Drinks Days out

Parents Children Friend Carer Other

AIDS / ADAPTATIONS

Accommodation: House / Flat / Walk-in-shower Down/Up Toilet Bath Board Grab Bars Banister 2-1-0
Other Glasses: Long/Near Hearing Aid Grabber Easy Grip Magnifier Joint support
Incontinence Aids Pads Commode Bottle Bucket Seat Raise
Mobility Car Stick Crutches Wheelchair Mobility Scooter Stair Lift / Hoist

GENERAL

Height Weight BMI Smoking Alcohol
 Right / Left / Ambidextrous Lives with adults Children Pets
Diet –cereal/toast/hot drinks/sandwiches/soup/cooked meals/ready meals/takeaways / Intolerance
Previous Occupations Sports / Gym Hobbies / Interests Holidays Study
Family Mother Father Brothers Sisters Children Other

SYMPTOMS	IMPAIRMENT	Anatomical Diagram		
Weakness <input type="checkbox"/>	Emotion		Cervical	
Pins & Needles <input type="checkbox"/>	CNS		Thoracic	
Numbness <input type="checkbox"/>	CardioResp		Lumbar	
Stiff joints <input type="checkbox"/>	Right Arm		Left Arm	Bladder/Bowels
Deformity	Joint		Right Leg	Left Leg
Atrophy				Weight
Range of motion				Variability
Crepitus				
Hypersensitivity				

FUNCTIONAL RESTRICTION			Disability Expert			
A Carry / Stack	F Continenence	L Motivation	M Learning			
B Mobility	G	N Vision	N Vision			
C Bending	H Emotional Control	P Hearing	P Hearing			
D Exercercise tolerance	J Social Skills	Q Balance / Falls	Q Balance / Falls			
E Manual Dexterity	K Change Tolerance	R Consciousness	R Consciousness			
Prognosis <input type="text"/>			I - Improve W- Worsen S- Stable			
			Impairment			
			Anatomy			
			Diagnosis			
			Restriction			
			Prognosis			

EXAMINATION		(Disability Expert)						
RUL	LUL	RLL	LLL	PSY	Loss	Conflict	Change	Identity
Grip	bend	squat	tiptoes	FEV1	FVC	PFR		
C	T	L	SI	CNS	Memory	Cranials	Sequence	Clock
			Sciatic	Heart and chest	VA –Near	VA-Far		
Hands		Wrist	Pain	Shoul		Ankle	Pain	Hips
		ROM	Elbow	Ders		ROM	Knee	ROM

OBSERVATIONS		(Disability Expert)							
Slight / Heavy / Stick / Walks with one / Balance / Halt / Speed <input type="text"/>		Inconsistency <input type="checkbox"/> Medical <input type="checkbox"/> Treatment <input type="checkbox"/> Typical Day <input type="checkbox"/> Examination <input type="checkbox"/>							
Distance <input type="text"/>									
<input type="checkbox"/> Stairs	<input type="checkbox"/> Secs	Up <input type="checkbox"/>	Foot <input type="text"/>	Down <input type="checkbox"/>	Foot <input type="text"/>				
Behaviour	Volume / Speed	Eye Contact	Irritable	Restless	Appearance	Nutrition	Moves Freely	Injury	Home
	Appropriate	Rapport	Tearful	Disinhibited		Dressed	Antalgic	Grooming	Garden