

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Physical Exam: Vital signs:** pulse \_\_\_\_\_ resp \_\_\_\_\_ temp \_\_\_\_\_

**Appearance:** well developed, well nourished, well groomed, obese, thin

**Mood and Affect:** alert, attentive      **Orientation:** person, place & time

**Gait:** ataxia, limp, normal

**Use of assistive device:** Yes No  
type: wheelchair, walker, crutches, cane

**Musculoskeletal Assessment:**

Circle site of complaint:	LLE	RLE	LUE	RUE	Neck	Spine/Pelvis
Range of Motion	full	full	full	full	full	full
(crepitation)						
Asymmetry	no	no	no	no	no	no
Masses	no	no	no	no	no	no
Effusion	no	no	no	no	no	no
Stability(Laxity )	no	no	no	no	no	no
Muscle atrophy	no	no	no	no	no	no
Deep Tendon Reflexes	+ knee	-	+ elbow	-		
Lymph nodes	no	no	no	no	no	no
Skin(rash,lesion,ulcers)	no	no	no	no	no	no

Assessment by: \_\_\_\_\_

**REVIEWED BY:** \_\_\_\_\_,MD      **DATE:** \_\_\_\_\_