

### Face-to-Face Mobility Examination Report For a Power Wheelchair

Patient Information					Date of Face to Face Examination: _____	
Name: _____					HIGN: _____	
Mailing Address: _____					Telephone: ( ) _____	
City: _____	State: _____	Zip: _____	DOB: _____	Age: _____	Male <input type="checkbox"/>	Female <input type="checkbox"/>

## Physician or Treating Practitioner Information:

Name:		UPIN:
Mailing Address:		Telephone: ( )
City:	State:	Zip:

**Current Symptoms, Related Diagnoses, and History** (Must Be Completed by Treating Practitioner)

What medical conditions/diseases limit your patient's mobility in their home?

<input type="checkbox"/> Cerebral Vascular Disease / CVA	<input type="checkbox"/> Hemiplegia/Hemiparesis	<input type="checkbox"/> Paraplegia/paresis
<input type="checkbox"/> COPD	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> CHF	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Spinal Failure
<input type="checkbox"/> Degenerative Joint Disease	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Diabetes/Hypertension		
<input type="checkbox"/> Other, Please describe:		

How do the above conditions interfere with their ability to perform Activities of Daily Living (ADLs) in their home?

<input type="checkbox"/> Abnormality of Gait	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> De-conditioning	<input type="checkbox"/> Numbness	<input type="checkbox"/> Tremor
<input type="checkbox"/> Stiffness	<input type="checkbox"/> Pain	<input type="checkbox"/> Weakness
<input type="checkbox"/> Other, Please describe: _____		

Physikalisches Institut (Abteilung für Experimentelle Physik)

HE:	MC:	SEP:	Pulse (resting):	Pulse (action):
Shortness of Breath at Rest? Y N	Shortness of Breath w/exercise? Y N	Is O2 required? Y N	Number of Liters?	O2 Sat?
Any current pressure sores? Y N	History of pressure sores? Y N	Location?	Stage?	Able to shift weight? Y N
Post Balance Y N	Post Endurance Y N	History of Falls Y N	Risk of Falls Y N	Significant Edema Y N
Upper Body Weakness: _____ Mild _____ Moderate _____ Severe Upper Body Pain: _____ Mild _____ Moderate _____ Severe Lower Body Weakness: _____ Mild _____ Moderate _____ Severe Lower Body Pain: _____ Mild _____ Moderate _____ Severe Cast Pattern: _____ Non-Ambulatory _____ Max Assist _____ Mod Assist _____ Atoxic _____ Shuffling Cast/Injury: _____ RUC / LUE _____ RLE / LLE				

# Face To Face Mobility Examination Report

**Amy Dix**



## Face To Face Mobility Examination Report:

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examination this is an ideal textbook for courses in OMT It also serves as a reference for all manual medicine practitioners including physical therapists chiropractors osteopaths and medical physicians      *Resources in Education* ,2001-04      *St. Thomas's Hospital Reports* St. Thomas's Hospital (London, England),1903      **Reports of Civil and Criminal Cases Decided by the Court of Appeals of Kentucky, 1785-1951** Kentucky. Court of Appeals,James Hughes,Achilles Sneed,Martin D. Hardin,George Minos Bibb,Alexander Keith Marshall,William Littell,1921      **CRREL Report** ,1990      **Research in Education** ,1971-12      **Saint Thomas's Hospital Reports** St. Thomas' Hospital (London, England),1903      *Records & Briefs New York State Appellate Division* ,

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