



THERAPRACTICS ANKLE & FOOT RE-EVAL

PATIENT: _____ DATE: _____

PATIENT #: _____ EMPLOYER: _____

DIAGNOSIS: _____ PHYSICIAN: _____

GENERAL COMMENTS

Pain level & % improvement: _____

Since the Initial Eval. on _____ / Re-Eval. on _____ the patient has had _____ treatments.

The patient's physical therapy treatment program has consisted of: Ther. Exs. STM Jt. Mobs. IFC

U.S. Iontophoresis Other: _____

The patient has had a total of _____ treatments since the Initial Evaluation.

ASSESSMENT / OBJECTIVE

PALPATION: _____

CLINICAL OBSERVATION (Swelling, redness, etc.) _____

Circumference around malleoli: RIGHT: _____ " LEFT: _____ "

ANKLE/FOOT R.O.M. /STRENGTH: LEFT RIGHT FOOT ARCH: LEFT RIGHT

ANKLE DORSIFLEXION	°	/5	°	/5	HIGH ARCH		
ANKLE PLANTARFLEXION	°	/5	°	/5	FLAT FOOT		
ANKLE INVERSION	°	/5	°	/5	Achilles bows in		
ANKLE EVERSION	°	/5	°	/5	Achilles bows out		

SUMMARY: The patient has made Good Fair Poor progress in physical therapy.

Additional comments: _____

Recommend that the patient be Discharged to a H.E.P. Continue with the following treatment plan:

Treatment Plan: Ther. Exs. STM Jt. Mobs. IFC U.S. Iontophoresis Other: _____

Frequency: _____ x/wk. Duration: _____ wks.

R.P.T., D.C.