KEMENTERIAN KESIHATAN MALAYSIA
PHYSIOTHERAPY DEPARTMENT
SPINAL INJURY ASSESSMENT FORM

Name :---------- Age: --------- Sex: M / F RN /IC : ----------Date :----------

DIAGNOSIS

ASIA Score:

DOCTOR'S MANAGEMENT

PROBLEM

SPECIAL QUESTIONS

Date of Surgery

Occupation

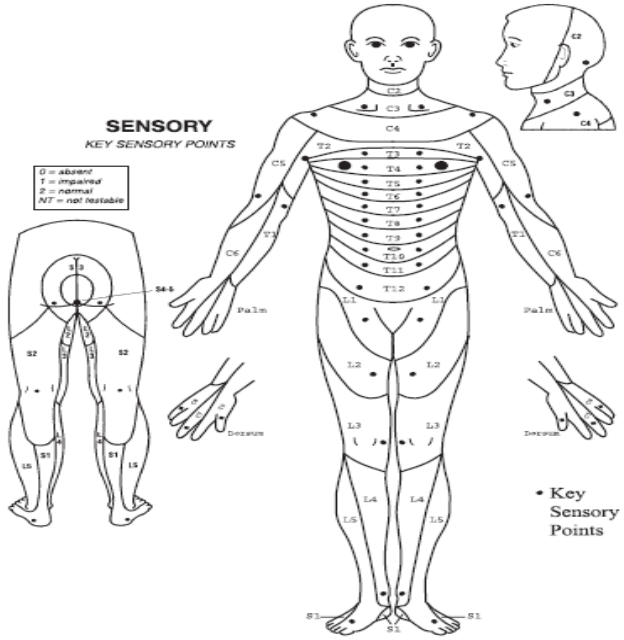
Investigation

CURRENT HISTORY

PAST HISTORY

UPRIGHT CONTROL (Incomplete) (Good/ Fair/Poor)	**Flex**		**Ext**	
	Lt.	**Rt.**	**Lt.**	**Rt.**
Hip				
Knee				
Ankle				

SENSORY EVALUATION
(N- Normal/ I- Impaired/ A- Absent)



MUSCULOSKELETAL EVALUATION

		MMT		**PROM**		**MAS**	
		Lt.	**Rt.**	**Lt.**	**Rt.**	**Lt.**	**Rt**
NECK	Flex.						
	Ext.						
SCAPULA	Elev.						
	depression						
	protraction						
	retraction						
SHOULDER	Flex.						
	Ext.						
	Abd.						
	Add .(Horiz)						
ELBOW	Flex.						
	Ext.						
WRIST	Flex.						
	Ext.						
FINGER	Flex.						
	Ext.						
TRUNK	Flex.						
	Ext.						
HIP	Flex.						
	Ext.						
	Abd.						
	Add.						
	Int. Rot.						
	Ext. Rot.						
KNEE	Flex.						
	Ext.						
ANKLE	P.Flex.						
	D.Flex.						
SUBTALAR	Inv.						
	Eve.						
TOE	Flex.						
	Ext.						

	Pin Prick		**Light Touch**	
	Lt.	**Rt.**	**Lt.**	**Rt.**
C 2				
C 3				
C 4				
C 5				
C 6				
C 7				
C 8				
T 1				
T 2				
T 3				
T 4				
T 5				
T 6				
T 7				
T 8				
T 9				
T 10				
T 11				
T 12				
L 1				
L 2				
L 3				
L 4				
L 5				
S 1				
S 2				
S 3				
S 4				

	Rt.	Lt.
SHOULDER		
ELBOW		
WRIST		
THUMB		
HIP		
KNEE		
ANKLE		
BIG TOE		

ASSISTIVE AIDS
(Please tick appropriately)

Wheelchair	Standard	
	Light Weight	
	Power	
Cushion	Jay	
	Air Filled	
	Foam	
Orthosis	……. (Please state)	

RESPIRATORY EVALUATION
(Please tick appropriately)

Breathing Pattern	Usage of neck accessory muscle	
	Apical	
	Abdominal	
	Diaphragm	
Cough	Functional	
	Weak	
	Non-functional	
Diaphragm Function	Vital Capacity (VC)	…….
	Peak Expiratory Flow Rate (PEFR)	…….

PAIN SCORE:

Pre	
Post	

FUNCTIONAL EVALUATION

A.Body Handling Skills
(U – Unable, A – Assisted, S- Supervised, I – Independent)

Roll side to side	
Come to sit	
Shift	
Raise (Off pressure)	

B. Balance
(G- Good, F – Fair, P- Poor)

Static	
Dynamic	

C.Transfer
(U – Unable, A – Assisted, S- Supervised, I – Independent)

Bed	
Chair	
Floor	
Car	
Toilet/ Commode Chair	

D. Wheelchair Mobility
(U – Unable, A – Assisted, S- Supervised, I – Independent)

Level Propulsion	
Ramp	
Curbs	
Rough Terrain	
Wheelie	

E. Walking (With/ without aids)
(U – Unable, A – Assisted, S- Supervised, I – Independent)

Sit to stand	
Level	
Rough Surface	
Stairs	

SKIN INTEGRITY

HOME ENVIRONMENT

OUTCOME MEASURES (Please choose appropriately)

A. 10 Meter Walk Test:_____

B. Walking Index For Spinal Cord Injury (WISCI)

Score	

PHYSIOTHERAPIT'S IMPRESSION

SHORT TERM GOALS

LONG TERM GOALS

PLAN OF TREATMENT

Attending Physiotherapist: …….

Date : Sign and Stamp

KEMENTERIAN KESIHATAN MALAYSIA
GUIDELINES FOR USE OF SPINAL INJURY ASSESSMENT FORM

DOCTOR'S DIAGNOSIS
- As in referral.

DOCTOR'S MANAGEMENT.
- In brief conservative or operative.

PROBLEMS.
- Presenting complaint and the duration.
- Functional activity, pain, stiffness, weakness etc.

SPECIAL QUESTIONS

Date of Surgery
- Date of operation that patient has had.

OCCUPATION
- To note how extent of injury will disturb patient's work and ADL (active daily live).
- To know whether patient can go back to original work or modified / suggestion to other suitable work.

INVESTIGATION
- Briefly any Ix done, date and findings.

CURRENT HISTORY
- Date of present medical history.

PAST HISTORY
- Relevant past history with regards to the presenting problem
- Has it occurred before?
- Onset, progression, physiotherapy treatment and effect

MUSCULOSKELETAL EVALUATION
- Strength - grading system 0-5 as usual for each muscle from neck to toe.
- P.Rom - passive range of motion that limited and interfere with function should be documented in RED and specific degree of ROM must recorded.
- Spasticity- record '0' when no spasticity and '+' when present.
- Also can grade it by use 'Ashworth Scale ' (refer to A, Appendix A)

UPRIGHT CONTROL
- Which refer to those patient who a incomplete injury and going for ambulation

SENSORY EVALUATION
- Should include superficial and light touch in all dermatomes.
- Record it as N= normal, I= impaired and A= absent.

PROPRIOCEPTION
- Test for joint sense for all joints from shoulder to toe.
- Record also as N= normal, I= impaired and A = absent.

ASSISTIVE AIDS
- To note what equipment is suitable for the patient

- Type of wheelchair
- Type of cushion.
- Type of orthosis

RESPIRATION EVALUATION

- Breathing pattern and cough - tick appropriately.

DIAPHRAGM FUNCTION

- VC-to get from spirometer
- PEFR- to get from peep flow meter.
- Reading below than normal will influence the exercise tolerance

PAIN SCORE

0 …….10. Indicate on pain scale, level of pain as indicated by patient

Comments:

- Define area, nature of pain, aggravating factors, easing factors, pattern over 24 hours and irritability.

FUNCTIONAL EVALUATION

- Grade according to guideline given
- Set goals in initial assessment and current assessment.

SKIN INTEGRITY

- To check any possibility to get pressure sore, dehydration, trophic changes or others skin problems.

HOME ENVIROMENT

- Flat, double stories, bungalow etc.
- Relate with functional activity especially when patient plan for d/c later.
- Any modification and suggestion to take depending on patient disability (during home visit)

OUTCOME MEASURES

- 10 Meter Walk Test
- Spinal Cord Independence Measure (SCIM)
- Walking Index For Spinal Cord Injury (WISCI)

PHYSIOTHERAPIST IMPRESSION

- To note down patient's problems from physiotherapist point of view.

SHORT TERM GOALS

- The goals set according to priority which includes the expected outcomes and timeframe.

LONG TERM GOALS

- The goals set for a longer time frame based on patient's goals and physiotherapist's goals.

PLAN OF TREATMENT

- The physiotherapist's treatment plan that is to be carried out for the patient according to the goals set up.

SIGN/ STAMP/DATE

- Need to be filled by attending physiotherapist