Physical Therapy Assessment

Name: ____________________________________
Date: _____________
Height: ___________
Weight: ___________

MEDICAL TREATMENT

Type of Cancer: _______________________

Surgery? No ___ Yes___ Date of Surgery? _______ Mastectomy?___ Partial Mastectomy ?___

Reconstruction? No ___ Yes___ Date?___ What Type?___________________________________

Chemotherapy? No___ Yes___ Date of Completion?_______

Radiation Therapy? No___ Yes___ Date of Completion?______ (recommend completion of treatment four weeks before beginning WeCanRow)

Hormonal Therapy? No___ Yes___ What Type?____

PT ASSESSMENT- RANGE OF MOTION

SHOULDER ROM	**WNL (√)**	**Limitations**	**Home Exercises Given (√)**
Flexion standing/in supine	/		
Abduction standing/in supine	/		
External Rotation in supine			
Horizontal Abduction			
Horizontal Adduction			
Rowing			
Overhead Press			
LEG ROM			
Squat			
Hip Flexors			
Hamstrings			
Calves			

Physical Therapy Assessment- Cont.

PT ASSESSMENT- STRENGTH

UPPER BODY	WNL (√)	Limitations	Home Exercises Given (√)
Shoulder Press			
Triceps			
Lats			
Pecs			
Serratus			
Rhomboids			
Traps			
Grip Strength			
LOWER BODY			
Squats			
TRUNK			
Abdominals			

OTHER COMMENTS IF APPLICABLE

Pain:

Fatigue:

Numbness, Tingling:

Balance Issues:

Edema:

Tissue Mobility (anterior and lateral chest wall, axilla):

Donor Site Status (if post-surgical)

PT Signature: ____ **Date:**___________

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