Stroke Rehabilitation Assessment of Movement

Patient Information:

Name: ________________________________

Date of Birth: ________________________________

Date of Assessment: ________________________________

Rehabilitation Therapist: ________________________________

Medical History:

I. Initial Assessment:

A. Range of Motion (ROM):

1. **Upper Limb:**
    - Shoulder Flexion/Extension: ________________________________
    - Shoulder Abduction/Adduction: ________________________________
    - Elbow Flexion/Extension: ________________________________
    - Forearm Pronation/Supination: ________________________________
    - Wrist Flexion/Extension: ________________________________
    - Finger Flexion/Extension: ________________________________
2. **Lower Limb:**
    - Hip Flexion/Extension: ________________________________
    - Hip Abduction/Adduction: ________________________________
    - Knee Flexion/Extension: ________________________________
    - Ankle Dorsiflexion/Plantarflexion: ________________________________
    - Toe Flexion/Extension: ________________________________

B. Strength Assessment:

1. **Upper Limb:**
    - Shoulder: ________________________________
    - Elbow: ________________________________

- Wrist: ___________________________________
- Grip Strength: ___________________________________

2. **Lower Limb:**
   - Hip: ___________________________________
   - Knee: ___________________________________
   - Ankle: ___________________________________

C. Coordination and Balance:

1. **Functional Mobility:**
   - ____
   - ____
   - ____
2. **Balance:**
   - ____
   - ____

II. Task-Specific Assessment:

A. Activities of Daily Living (ADLs):

1. **Self-Care:**
   - Dressing: ___________________________________
   - Eating: ___________________________________
   - Personal hygiene (brushing teeth, combing hair, etc.): _____________________________
2. **Functional Tasks:**
   - Lifting objects: ___________________________________
   - Reaching for objects: ___________________________________
   - Handling utensils: ___________________________________

B. Fine Motor Skills:

1. **Grasping Objects:**
   - ____
   - ____
2. **Manipulative Skills:**
   - ____

- ____

C. Gross Motor Skills:

1. **Walking and Gait:**
    - ____
    - ____
    - ____
2. **Transfers:**
    - ____
    - ____

III. Specific Assessment Tools:

A. [Specify any standardized assessment tools used, such as the Fugl-Meyer Assessment, Modified Rankin Scale, etc.]

1. ____
    - ____
    - ____
    - ____
2. ____
    - ____
    - ____
    - ____

IV. Progress Notes and Recommendations:

1. **Progress Since Last Assessment:**
    - ____
    - ____
    - ____
2. **Recommendations for Future Therapy:**
    - ____
    - ____
3. **Home Exercise Program:**
    - ____

- ____

V. Therapist's Signature:

Therapist's Name: ________________________

Therapist's Signature: ________________________

Date: ________________________