Thomas Test

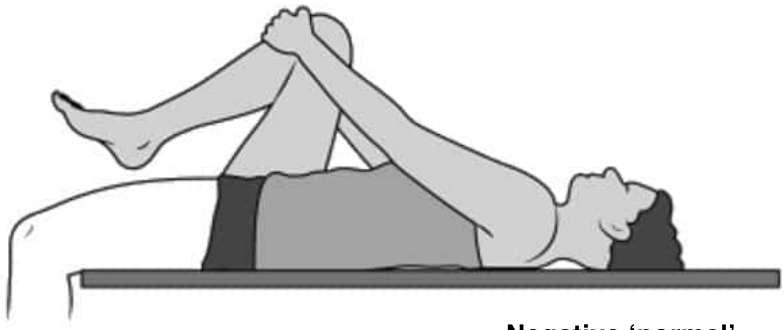
Client Information

Name: _____ Date of birth: _____

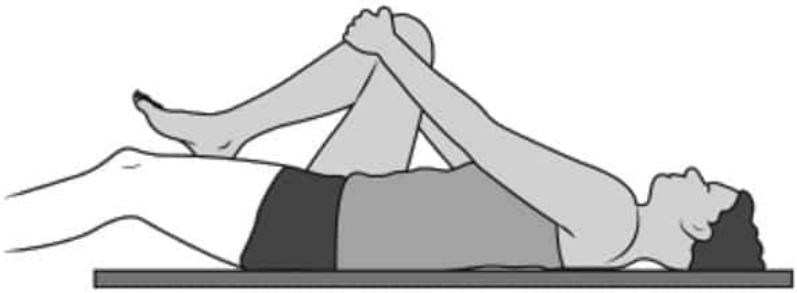
Gender: _____ Date of Consultation: _____

Address: _____

Phone Number: _____ Email Address: _____



Negative ‘normal’



Positive

Description of the patient’s condition

Illustration: ORTHOFIXAR

Severity of Pain:

Recommendation:

Notes: