



ASSESSMENT FORM

Personal Details:

Name:

Date:

Cancer Type:

Date of Diagnosis:

under 2 yrs

Medical insurance: yes No

Cancer Treatment:

Type of Surgery and adjuvant treatment:

Surgery Type and date : _____

Lymph node removal Number of nodes removed **R** **L**

Cancer treatments :

Hormone therapy: yes No to come

Chemotherapy: yes No to come

Radiation Therapy: yes No to come

Additional Adjuvant Intervention information:

Current medications:

Side effects from medication:

Ongoing plan for cancer treatment:

Experiencing post op or constant pain: yes No

Pain intensity 0 – 10 scale

Body site:

Aggravating factors:

Other current musculoskeletal issues:

Lymphoedema: yes No Unsure Seeing lymphoedema specialist

Functional Limitations: Home:

Work:

Exercise prior to cancer diagnosis:

Current exercise:

Average time spent exercising each week:

Fatigue: 1 – 3 (mild) { 4 – 6 (mod) 7 – 10 (severe) } → complete additional fatigue assessment

Musculoskeletal Objective Assessment:

Resting posture observations:

NAD

ROM measures:

flex. R L abd. R L intl rot. R L ext rot. R L ext. R L

Muscle strength:

NAD

Skin screening

Skin changes observation:

NAD

Scar tissue assessment:

Bladder Function

NAD

Phase of Recovery (circle): post op recovery fitness

Patient Goals from the Steel Program:

- 1.
- 2.
- 3.

Date	Therapist Goals	Treatment Plan

HEP and exercise plan:

- Treatment has been explained to Client
- Consent Gained for Treatment
- Consent Gained to inform GP or Surgeon of participation in Steel Program

Therapist: _____ Signed: _____ Date: _____