

PD REHAB Trial Participant	Name:		Trial No: <input type="text"/>		
	DOB:		Date of Assessment:		

Purpose of session – record time in minutes

INITIAL INTERVIEW

One to one or group session.....

Location of Intervention.....(DESCRIBE - for example - Pt's home / Out-patient Clinic / Pt's local shopping area / Pt's work place / Other)

	1. Gait and indoor mobility	2. Outdoor mobility	3. Balance and falls	4. Transfers	5. Posture	6. Physical Conditioning	7. Upper-Limb Function	8. Self-Care	9. Domestic ADL	10. Leisure-related activities	11. Work-related (paid and non-paid) activities	12. Other
Initial assessment												
Goal setting												
Ongoing assessment and review												
Compensatory strategies												
Cueing and cognitive strategies												
Visual, auditory (including verbal), and sensory feedback												
Strength training												
Flexibility training												
Coordination and movement control training												
Aerobic/ endurance training												
Balance training												
Functional, task-specific training												
Education, advice and information												
Provision of aids and equipment												
Training of caregiver(s)												
Liaison												
Referral												
Other												

Assessment completed by..... Date/...../.....

Signed.....