STRENGTH for life 50+

COTA For older Australians

ASSESSMENT SUMMARY - TIER 2

Client's Name: ____

Address: ____

Contact Telephone: ____________________ Date of Birth: ___________

Please complete relevant information in the following sections.

An appropriately qualified health professional will prescribe a progressive strength training program.

Medical History

____

____

____

____

____

____

____

Relevant information regarding medication

____

____

____

____

____

Physical Restrictions and Contraindications to strength training exercises – implications for daily living

____

____

____

____

Postural Assessment

At wall ____

Head position____

Hands Position ____

Shoulders____

Comments____

Recommended strength training exercises for this client

____

____

____

____

Assessors Name: ____

Organisation: ____

Telephone: _______________________

Signature: ________________________ Date: ____________