



THE MCKENZIE INSTITUTE RE-ASSESSMENT FORM

Date _____ Name _____ Visit Number _____

Check of Management Strategies:

Posture Change: Yes / No

Performing Exercises: Yes / No

Frequency: Appropriate / Not appropriate Symptom Response when performing exercises _____

Technique: Good / Needs correcting

Adherence / Commitment Excellent / Good / Fair / Poor

Symptomatic Presentation:

Pain Location: Centralised / Same / Peripheralised _____

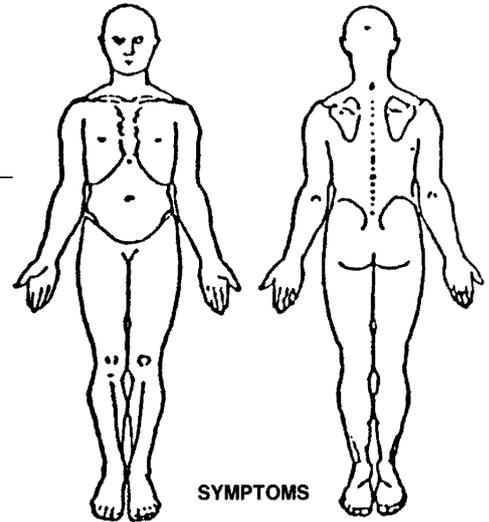
Frequency: Better / Same / Worse

Severity: 0 _____ 10
Better / Same / Worse

Functional Status: % improvement since initial assessment:

0 _____ 100%

Functional questionnaire: _____



Mechanical Presentation:

Sitting Posture: Consistent with plan; yes / no

Standing Posture: Consistent with plan; yes / no

Deformity: Yes / No / Not applicable

Neurological Testing: Better / Same / Worse / Not applicable _____

Movement Loss: Better / Same / Worse _____

Current Exercise Technique: Good / Needs correcting

Symptom Response: _____

Repeated Movements: Better / Same / Worse

SUMMARY: Better / Same / Worse

Overall improvement since initial assessment: 0 _____ 100%

Classification Confirmed: Yes / No

Further Testing (if required): Repeated Movements: _____

Other Testing: _____

Revised Classification (if appropriate):

Derangement Dysfunction Postural OTHER (subgroup) _____

Management Today:

Education: _____

Treatment: _____

Plan: _____

Potential Drivers of Pain and / or Disability: _____

Equipment Provided: Lumbar Roll _____ Cervical Roll _____

TYOB/TYON/TYOS/TYOK/TYOH _____ **Night Roll** _____ **Signature** _____