**PASSIVE RANGE OF MOTION**

**LOWER EXTREMITIES**

**Name :**

**Date of Birth :**

**Country :**

|  |  |  |  |
| --- | --- | --- | --- |
| **Hip** | **Norm** | **Result** | |
| **Right** | **Left** |
| **Flexion** | **0-120** | /120 | /120 |
| **Extension** | **0-30** | /30 | /30 |
| **Abduction** | **0-45** | /45 | /45 |
| **Adduction** | **0-30** | /30 | /30 |
| **Internal rotation** | **0-45** | /45 | /45 |
| **External rotation** | **0-45** | /45 | /45 |

|  |  |  |  |
| --- | --- | --- | --- |
| **Knee** | **Norm** | **Result** | |
| **Right** | **Left** |
| **Flexion** | **0-140** | /140 | /140 |
| **Extension** | **0** | /0 | /0 |

|  |  |  |  |
| --- | --- | --- | --- |
| **Ankle** | **Norm** | **Result** | |
| **Right** | **Left** |
| **Plantarflexion** | **0-50** | /50 | /50 |
| **Dorsiflexion** | **0-20** | /20 | /20 |

Date:

Medical Practitioner name and title:

Medical Practitioner signature: