

**PATIENT EXERCISE
SHEET
BED EXERCISES
NEUROLOGY**

DRAFT



Diagnosis: _____

Specific Precautions/Contraindications: _____

Date				
Transfers: Indep/Supervision/ Assist x 1 or 2				
Gait: Indep/Supervision/ Assist x 1 or 2				
Gait aid: standard walker / 2WW / HWW / Rollator / LBQC / SBQC / SPC				
Repetitions (eg. 10, 10-15)				
A: <u>Sitting EOB, weight-shifting</u> <input type="checkbox"/> APT <input type="checkbox"/> Forwards/backwards <input type="checkbox"/> Side to Side				
B: <u>Supine, Crook-lying</u> <input type="checkbox"/> Bridging <input type="checkbox"/> Pelvic rotation (bilat) <input type="checkbox"/> Knee side to side (unilat)	<input type="checkbox"/> Non skid <input type="checkbox"/> Theraband	<input type="checkbox"/> Non skid <input type="checkbox"/> Theraband	<input type="checkbox"/> Non skid <input type="checkbox"/> Theraband	<input type="checkbox"/> Non skid <input type="checkbox"/> Theraband
C: <u>Shoulder flexion</u>	<input type="checkbox"/> Hands intertwined <input type="checkbox"/> Wand ____lbs <input type="checkbox"/> AROM ____lbs	<input type="checkbox"/> Hands intertwined <input type="checkbox"/> Wand ____lbs <input type="checkbox"/> AROM ____lbs	<input type="checkbox"/> Hands intertwined <input type="checkbox"/> Wand ____lbs <input type="checkbox"/> AROM ____lbs	<input type="checkbox"/> Hands intertwined <input type="checkbox"/> Wand ____lbs <input type="checkbox"/> AROM ____lbs
D: <u>LE Strengthening in Supine</u> <input type="checkbox"/> Hip Flex <input type="checkbox"/> Hip Abd <input type="checkbox"/> QOR	<input type="checkbox"/> PB <input type="checkbox"/> Plain bed R ____lbs L ____lbs	<input type="checkbox"/> PB <input type="checkbox"/> Plain bed R ____lbs L ____lbs	<input type="checkbox"/> PB <input type="checkbox"/> Plain bed R ____lbs L ____lbs	<input type="checkbox"/> PB <input type="checkbox"/> Plain bed R ____lbs L ____lbs
E: <u>LE Strengthening in Sitting</u> <input type="checkbox"/> Knee flex <input type="checkbox"/> Knee Ext <input type="checkbox"/> Marching	R ____lbs L ____lbs	R ____lbs L ____lbs	R ____lbs L ____lbs	R ____lbs L ____lbs
F: <u>Sit to Stand</u> <input type="checkbox"/> Supported <input type="checkbox"/> No support				
G: <u>UE Strengthening in Sitting</u> _____ _____ _____				

Patient consents to weekend therapy class Yes No

PT Signature: _____ **PTA Signature:** _____

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