



PT/PTA SKILLS CHECKLIST

Name _____ Date _____ Exp since _____

| | Comfortable with | Done Occasionally | No Experience |
|--------------------------------|--------------------------|--------------------------|--------------------------|
| <u>I. Orthopedics</u> | | | |
| 1. Arthritis Program | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. General Ortho | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Hand Injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Hip Fractures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Mobilization Techniques | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Total Hip/Total Knee | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Total Joint Replacement | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>II. Neuro</u> | | | |
| 1. Cerebral Vascular Accident | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Cognitive Retraining | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Head Trauma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Spinal Cord Injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Parkinson's Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>III. Pediatric</u> | | | |
| 1. Cerebral Palsy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Developmental Screening | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Early Intervention | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Learning Disabilities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Neurodevelopment Testing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Sensory Integrative Testing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Spinal Bifida | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Visual Perception Testing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Autism | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Down's Syndrome | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Mental Retardation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



IV. Modalities

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|----------------------------|--------------------------|--------------------------|--------------------------|
| 1. Biofeedback | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Edema Massage | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Feeding Techniques | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Fluidotherapy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Oral Motor Facilitation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Muscle Stimulation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Paraffin Bath | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. TENS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Therapeutic Massage | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Therapeutic Pool | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

V. Prosthetics/Orthotics

- | | | | |
|------------------------------|--------------------------|--------------------------|--------------------------|
| 1. Dynamic Splints | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Functional Splinting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Orthotics | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. LE Prosthetics | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Serial/Inhibitory Casting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Static Splints | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. UE Prosthetics | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

V. Prosthetics/Orthotics

- | | | | |
|-------------------------------|--------------------------|--------------------------|--------------------------|
| 1. Activities Of Daily Living | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Adaptive Equipment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Amputees | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Burn Management | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Driving Evaluation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Dysphasia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Energy Conservation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Family Education | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Gait Analysis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Geriatrics | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Group Dynamics | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Home Accessibility | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Job Task Analysis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Oncology | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Pain Management | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



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|---------------------------------|--------------------------|--------------------------|--------------------------|
| 16. Perceptual Motor Testing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Pulmonary Rehab | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Range of Motion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Sensation Testing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Static Splints | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Wheelchair Position Testing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Wheelchair Position Testing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Work Capacity Evaluation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Work Hardening | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

VII. Work Setting

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|-----------------------------|--------------------------|--------------------------|--------------------------|
| 1. General Acute Care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Home Health | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Nursing Home | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Outpatient Clinic | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Pediatric Rehab | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Acute Rehab Hospital | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Rehab Unit in a Hospital | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. School System | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Name _____ Date _____

Signature _____