

MUSCULAR ASSESSMENT CHECKLIST

Physical Therapy Division

Patient Name: _____
Date: _____
Clinician: _____
ID#: _____

**MUSCLE GROUP /
AREA**

TIGHTNESS

WEAKNESS

**CLINICAL
OBSERVATIONS /
PAIN LEVEL**

Cervical Paraspinals

Upper Trapezius

Rotator Cuff (SITS)

Lumbar Extensors

Iliopsoas / Hip Flexors

Gluteus Medius/Max

Quadriceps

Hamstrings

Gastrocnemius/Soleus

Manual Muscle Test (MMT) Scale: 0: No contraction 1: Trace 2: Poor 3: Fair 4: Good 5: Normal

Specific Recommendations:

TEMPLATE ONLY - NOT AN OFFICIAL DIAGNOSTIC TOOL