



PHYSICAL THERAPY SKILLS CHECKLIST

Date: _____

Full Name: _____

INSTRUCTIONS

Please provide accurate answers so we can correctly match your abilities to our client job requirements. Please check the level of experience and expertise you have in each skill category, using the following scale:

#1 = Familiar with procedure but will usually or almost always require some assistance.

#2 = Competent and familiar with procedure: I can perform this procedure with excellence, usually without assistance.

#3 = Very competent: I have at least 12 months experience and can perform this procedure with excellence and without assistance.

NOTE: Leave blank any procedures which you have **no experience, training or low competence.**

| SKILLS: | 1 | 2 | 3 |
|---|---|---|---|
| Orthopedic | | | |
| Arthritis programs | | | |
| Back syndromes | | | |
| Hand injury | | | |
| Hip fractures | | | |
| Mobilization techniques | | | |
| Neck injuries | | | |
| Total hip/knee replacement | | | |
| Total joint replacement/upper extremities | | | |
| Transmandibular joint dysfunction | | | |
| Neurologic | | | |
| Head trauma | | | |
| Neurosurgery | | | |
| Spinal cord injury | | | |
| Stroke rehabilitation | | | |
| Adaptive equipment | | | |
| Functional splinting | | | |
| Sports Medicine | | | |
| Biodex | | | |
| Bracing/joint immobilization | | | |
| Cybex | | | |
| LIDO | | | |
| Nautilus/Eagle | | | |
| Orthotron | | | |
| Strength and endurance training | | | |
| Taping/strapping | | | |
| Modalities/Manual Skills | | | |
| Acuscope | | | |
| Biofeedback | | | |
| Continuous passive motion machine | | | |
| Craniosacral therapy | | | |
| Cryotherapy | | | |

| SKILLS: | 1 | 2 | 3 |
|------------------------------------|---|---|---|
| Diathermy | | | |
| Electro-acupuncture | | | |
| Extremity mobilization | | | |
| Fluidotherapy | | | |
| Hot/cold packs | | | |
| Hydrotherapy | | | |
| Hubbard tank | | | |
| Therapeutic pool | | | |
| Whirlpool | | | |
| Massage | | | |
| Muscle energy techniques | | | |
| Muscle stimulation | | | |
| Myofascial release techniques | | | |
| Neuro probe | | | |
| Paraffin | | | |
| Spinal mobilization | | | |
| Strain/counter strain techniques | | | |
| TENS | | | |
| Therapeutic exercise/home programs | | | |
| Traction | | | |
| Cervical | | | |
| Lumbar | | | |
| Ultrasound | | | |
| Vasopneumatic devices | | | |
| Wound dressing | | | |
| Prosthetics/Orthotics | | | |
| Above knee prosthetics | | | |
| Ankle foot orthosis | | | |
| Below knee prosthetics | | | |
| Dynamic splints | | | |
| Gait analysis | | | |
| Orthoplast/aquaplast | | | |
| Resting splints | | | |

| SKILLS: | 1 | 2 | 3 |
|------------------------------|----------|----------|----------|
| Serial/inhibitory casting | | | |
| Static splints | | | |
| Upper extremity prosthetics | | | |
| Pediatrics | | | |
| Cerebral palsy | | | |
| Early intervention | | | |
| Equipment assessment | | | |
| Activities of daily living | | | |
| Adaptive | | | |
| Gross motor assessment tools | | | |
| Learning disabled | | | |
| Mental retardation | | | |
| Neurodevelopmental treatment | | | |
| Orthotics | | | |
| Spina bifida | | | |
| Computerized Testing | | | |
| Fatigue-characteristics | | | |
| Fiber-type | | | |
| Functional strength | | | |
| Net muscular torque | | | |
| ROM | | | |
| Work-capacity | | | |

| SKILLS: | 1 | 2 | 3 |
|---------------------------------|----------|----------|----------|
| Other | | | |
| Burn management | | | |
| Cardiac rehabilitation | | | |
| Chest physiotherapy | | | |
| Computerized charting | | | |
| Functional capacity evaluation | | | |
| Geriatrics | | | |
| Inservice education | | | |
| Wheelchair/equipment assessment | | | |
| Work capacity evaluation | | | |
| AGE | | | |
| Newborn (birth-30 days) | | | |
| Infant (30 days - 1 year) | | | |
| Toddler (1 - 3 years) | | | |
| Preschooler (3 - 5 years) | | | |
| School Age (5 - 12 years) | | | |
| Adolescents (12 - 18 years) | | | |
| Young Adults (18 - 39 years) | | | |
| Middle Adults (39 - 64 years) | | | |
| Older Adults (64+ years) | | | |

Certification:

Please check the boxes below and indicate the expiration date for each certificate that you hold. If you do not know the exact date, please use the last date of the specific month (e.g., 05/31/2003).

| Certification | Expiration Date |
|---------------------------------|-----------------|
| <input type="checkbox"/> BCLS | |
| <input type="checkbox"/> CPR | |
| <input type="checkbox"/> Other: | |

I hereby certify all statements and claims as true and that any misrepresentation of the facts on this skills checklist is sufficient cause for dismissal at any time without prior notice even if I have been already employed.

Full Name: _____

Signature: _____

Reviewed by _____ : Date: _____