ATM®2 - Data Collection Form

Name of Clinic: _____Physical Therapist: _____
Client's Age: _____ Diagnosis/Injury: _____
Length of injury: _____ days/weeks/months/years

Primary symptom:
a. Pain
b. numbness/tingling/burning
c. limited range of motion
d. weakness
e. other_____

Secondary symptoms:
a. pain
b. numbness/tingling/burning
c. limited range of motion
d. weakness
e. other_____

Pain at rest: 0 1 2 3 4 5 6 7 8 9 10
none worst
Pain with activity: 0 1 2 3 4 5 6 7 8 9 10
none worst
Functional limitations:
a. Range of motion: flex _____ ext _____ L lat flex _____ R lat flex_____
Abd _____ add _____ L rot _____ R rot _____
b. Strength: 5/5 4/5 3/5 2/5 1/5 0/5
c. Single limb balance: normal good fair poor absent

After ATM2™ Treatment

Pain at rest: 0 1 2 3 4 5 6 7 8 9 10
none worst
Pain with activity: 0 1 2 3 4 5 6 7 8 9 10
none worst
Functional limitations:
a. Range of motion: flex _____ ext _____ L lat flex _____ R lat flex_____
Abd _____ add _____ L rot _____ R rot _____
b. Strength: 5/5 4/5 3/5 2/5 1/5 0/5
c. Single limb balance: normal good fair poor absent

Number of sessions on ATM2: _____
ATM2 treatment (Please number in order used):
____flexion ____extension ____lateral flexion ____rotation
____internal rotation ____external rotation ____abduction ____adduction
____flex/rot ____ext/rot ____other:_____

List any other treatment that was administered in conjunction with ATM2:
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____