Physical Therapy Practice Guidelines for Persons with Bleeding Disorders:
Physical Therapy Evaluation Components

The following practice guidelines were developed through the consensus of the therapists that work with patients with bleeding disorders and edited by the National Hemophilia Foundation's Physical Therapy Working Group. The information contained in the practice guidelines is not intended in any way to be used as primary medical advice or to replace medical advice. They are intended to guide the physical therapist caring for individuals with bleeding disorders in the important factors and elements of quality care.

The physical therapy evaluation is a vital part of the comprehensive evaluation of a person with a bleeding disorder and is aimed at identifying musculoskeletal limitations and vulnerabilities which impact function and quality of life. The physical therapist will determine the necessary evaluation components to be completed at each visit based on the PWBD's impairment, pain, and functional limitation as well as the type of visit.

Acute Musculoskeletal Bleed/Pain

1. Details of bleed onset and progression of symptoms
2. Mechanism of injury
3. Hemostasis management used to date and response to treatment (includes factor, non-factor, and non-infused products)
4. Other treatment (first aid/PRICE) used and response to treatment
5. Pain qualities, location, intensity, aggravating/alleviating factors
6. Pain with movement

Bleed History

1. Recent joint or muscle bleeds (since last visit)
2. Reasons for those bleeds
3. Previous target joints: location and number
4. Usual activities
5. Identification of bleeding patterns
6. Usual hemostasis management regime
    a. Factor Products (Plasma or Recombinant)
    b. Non-factor Injectable Products
    c. Intranasal Agents
    d. Oral Agents
7. Usual response to treatment for bleeds
8. Chronic Arthropathy: Location

Subjective interview and history:

1. Other Medical and surgical history
2. Pain history and treatment
3. Patient concerns and complaints
4. Social history: family, school or work, culture, language

5. ADL concerns
6. Participation in physical activity: exercise, sports, PE, recreation
7. Current equipment
8. Orthopedic issues
9. Educational needs: Health literacy, ESL, absences due to physical needs, 504/IEP

Objective Information:

1. Observation/Inspection
2. Palpation/Inspection of joints:
    a. at rest and during AROM
    b. note abnormalities
        i. synovitis
        ii. crepitus
        iii. swelling
        iv. temperature
        v. redness
        vi. spasm
        vii. atrophy
3. ROM:
    a. Passive ROM for the following movements (at a minimum)
        i. Shoulder - Flexion
        ii. Elbow - Flex/Ext, Pron/Sup
        iii. Hip - Flex/Ext
        iv. Knee - Flex/Ext
        v. Ankle - DF/PF
    b. Atypical end feel
    c. Muscle length/flexibility especially for two joint muscles
    d. Hypermobility

    Strength:
    e. Active Movement
        i. Compare to contralateral limb or, in case of chronic arthropathy, baseline measurements
        ii. Pain with movement
    f. MMT or functional strength for above mentioned ROM measurements
4. Posture and alignment: Standing (preferably) or sitting
    a. Standing
    b. Sitting
    c. LLD
5. Balance
6. Sensation and Proprioception
7. Observational gait analysis
8. Functional activities
9. Activities and participation throughout the lifespan
    a. Gross motor development

   b. School/work
   c. Physical activity/sports
   d. Leisure/Social/Cultural activities
   e. Self-Care
10. Special Tests
   a. Bleeding Disorder Specific
   b. Orthopedic
   c. Developmental
   d. Fall Assessment
   e. Neuromotor
11. MSKUS Imaging
12. Other