Workers' Compensation Division
Department of Consumer and Business Services

Lower Extremity Range of Motion

Worker's name: _____ DOI: _____ WCD #: _____

Range of motion: Report **active** range of motion in degrees of any joints ***applicable*** and the corresponding contralateral joint, if contralateral has no history of injury or disease. The values in parentheses are the norms established by the Workers' Compensation Division.

Right hip			**Left hip**		
extension (30°)	**-0-**	**flexion** (100°)	**extension** (30°)	**-0-**	**flexion** (100°)
adduction (20°)	**-0-**	**abduction** (40°)	**adduction** (20°)	**-0-**	**abduction** (40°)
internal rotation (40°)	**-0-**	**external rotation** (50°)	**internal rotation** (40°)	**-0-**	**external rotation** (50°)

Right knee			**Left knee**		
extension (0°)	**-0-**	**flexion** (150°)	**extension** (0°)	**-0-**	**flexion** (150°)

Right ankle			**Left ankle**		
dorsiflexion (20°)	**-0-**	**plantar flexion** (40°)	**dorsiflexion** (20°)	**-0-**	**plantar flexion** (40°)
eversion (20°)	**-0-**	**inversion** (30°)	**eversion** (20°)	**-0-**	**inversion** (30°)

Right foot (digits)

	Great toe			**2nd toe**			**3rd toe**			**4th toe**			**5th toe**		
flexion	dorsi		plantar	dorsi		plantar	dorsi		plantar	dorsi		plantar	dorsi		plantar
IP		**-0-**			**-0-**			**-0-**			**-0-**			**-0-**	
MP		**-0-**			**-0-**			**-0-**			**-0-**			**-0-**	

Left foot (digits)

	Great toe	**2nd toe**	**3rd toe**	**4th toe**	**5th toe**
flexion	dorsi plantar	dorsi plantar	dorsi plantar	dorsi plantar	dorsi plantar
IP	**-0-**	**-0-**	**-0-**	**-0-**	**-0-**
MP	**-0-**	**-0-**	**-0-**	**-0-**	**-0-**

Examining physician name and title (please print or type): _____

Signature: _____ Date of examination: _____