Trunk Impairment Scale (TIS) Assessment

PATIENT INFORMATION

Name: _____ Date of Assessment: _____ dd / mm / yyyy

Assessor's Name: _____

PART 1: STATIC SITTING BALANCE

1. Sitting Without Support

◯ 0 ◯ 1 ◯ 2

Notes:

2. Maintaining Sitting Balance (with eyes closed)

◯ 0 ◯ 1 ◯ 2

Notes:

PART 2: DYNAMIC SITTING BALANCE

1. Lateral Flexion - Right Score:

◯ 0 ◯ 1 ◯ 2

1. Lateral Flexion - Left Score:

◯ 0 ◯ 1 ◯ 2

Notes:

2. Rotation - Right Score:

◯ 0 ◯ 1 ◯ 2

2. Rotation - Left Score:

◯ 0 ◯ 1 ◯ 2

Notes:

PART 3: COORDINATION

1. Picking Up an Object from the Floor

◯ 0 ◯ 1 ◯ 2

Notes:

2. Moving from Sitting to Lying and Back

◯ 0 ◯ 1 ◯ 2

Notes:

Total Score (out of 14): _____

Assessor's Overall Observations and Comments: