Physical Therapy Initial Evaluation & Clinical Assessment

Comprehensive form for documenting a patient's initial physical therapy examination, clinical findings, and plan of care.

Patient Information

Please provide the patient's demographic and referral details.

Full Name *

Date of Birth *

Phone Number *

Email Address *

Date of Evaluation *

Referring Physician *

Diagnosis *

Insurance Provider

Subjective Examination

Details about the patient's current condition and history.

Chief Complaint *

History of Present Illness/Injury *

Mechanism of Injury *

Aggravating Factors *

Easing Factors *

Functional Limitations *

Patient's Goals *

Date of Onset *

Current Pain Level (0-10) *

Worst Pain in Last Week (0-10) *

Best Pain in Last Week (0-10) *

Have you had prior physical therapy for this issue? *

- ◯ Yes
- ◯ No

If yes, please describe prior physical therapy. *

Pain Description (check all that apply) *

- ☐ Sharp
- ☐ Dull
- ☐ Burning
- ☐ Throbbing
- ☐ Aching
- ☐ Shooting
- ☐ Tingling
- ☐ Numbness
- ☐ Radiating pain
- ☐ Constant
- ☐ Intermittent

Do you experience sleep disturbance due to your condition? *

- ◯ Yes
- ◯ No

Past Medical History

Please check any medical conditions that apply and provide additional details as needed.

Medical Conditions (check all that apply) *

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Stroke
- ☐ COPD/respiratory issues
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Cancer
- ☐ Neurological conditions
- ☐ Seizure disorder
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Depression/anxiety
- ☐ Joint replacement
- ☐ Pregnancy (current or possible)
- ☐ None
- ☐ Other _____

Please list any previous surgeries or hospitalizations. *

Current Medications *

Allergies *

Objective Examination

Physical findings and clinical observations.

Posture Findings *

Gait Pattern *

Reflexes *

Coordination *

Balance *

Special Tests Performed *

Results of Special Tests *

Deviations Observed (check all that apply) *

- ☐ Forward head
- ☐ Rounded shoulders
- ☐ Scoliosis
- ☐ Kyphosis

- [ ] Lordosis
- [ ] Pelvic tilt
- [ ] Gait deviations
- [ ] Asymmetry
- [ ] Other

Is an assistive device used? *

- ◯ Yes
- ◯ No

If yes, type of assistive device *

Cervical Range of Motion (ROM) *

Upper Extremity Range of Motion (ROM) *

Lower Extremity Range of Motion (ROM) *

Cervical Strength *

Upper Extremity Strength *

Lower Extremity Strength *

Sensation *

- ☐ Intact
- ☐ Impaired
- ☐ Absent

Functional Outcome Measures

Tests used to measure function and progress.

Test Used *

Score *

Notes *

Assessment

Summary of clinical findings and professional judgment.

Clinical Impression *

Identified Impairments *

Activity Limitations *

Participation Restrictions *

Factors Influencing Prognosis *

Rehabilitation Potential *

- ◯ Excellent
- ◯ Good
- ◯ Fair
- ◯ Poor

Plan of Care

Planned interventions and recommendations.

Planned Interventions (check all that apply) *

- ☐ Therapeutic exercise
- ☐ Neuromuscular reeducation
- ☐ Manual therapy
- ☐ Gait training
- ☐ Balance training
- ☐ Modalities
- ☐ Home exercise program
- ☐ Patient education
- ☐ Other

Frequency & Duration *

Home Exercise Program Instructions *

Referral Recommendations *

Goals

Patient-centered goals for therapy.

Short-term Goals *

Long-term Goals *

Consent & Acknowledgment

Please review and acknowledge the following statements.

I acknowledge that the information provided is accurate to the best of my knowledge. *

☐ I agree

I consent to the physical therapy evaluation and treatment plan as discussed. *

☐ I consent

Signatures

Sign and print names below.

Patient Printed Name *

Patient Signature (type full name) *

Date *

Evaluating Therapist Name *

Therapist Signature (type full name) *