



**Back in Motion<sup>®</sup>**  
PHYSICAL THERAPY LLC



## Physical Therapy Screening Report

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
*Physician Name & Address*

**RE:** \_\_\_\_\_  
*Patient Name, DOB*

Dear \_\_\_\_\_  
*Physician Name*

Your patient, \_\_\_\_\_, was seen for a screening in our clinic on \_\_\_\_\_  
*Patient Name* *Screening Date*  
regarding their \_\_\_\_\_. Please review the attached form for specific findings from the  
*Body Part*  
screening. From the findings, it appears your patient would benefit from physical therapy to address their deficits and limitations.

### Patient Information

Date of Screen \_\_\_\_\_ Presenting Problem \_\_\_\_\_

Onset \_\_\_\_\_

### Screening Report

Subjective \_\_\_\_\_

Objective \_\_\_\_\_

\_\_\_\_\_

Assessment \_\_\_\_\_

\_\_\_\_\_

Plan \_\_\_\_\_

### Recommendations

Patient could benefit from physical therapy \_\_\_\_\_ times/week for \_\_\_\_\_ weeks

Treatment to consist of \_\_\_\_\_

☐ Therapeutic Exercise ☐ Therapeutic Modalities ☐ Manual Therapy ☐ Soft Tissue/Joint Mobilization

☐ Patient Education ☐ Other \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Phone \_\_\_\_\_

If you have any questions or concerns, please contact me at your earliest convenience.