advent
PHYSICAL THERAPY

Initial Evaluation Form

Patient Name: _____ **Site:** _____

DOB: _____ **Account Number:** _____

Referring Physician: _____ **Date of Service:** _____

Primary Physician: _____ **Gender:** M or F

Therapist: _____

Diagnosis: _____ **Onset:** _____

Reason for Referral/Chief Complaint:

Date of Injury/Surgery: _____

_____

Mechanism Of Injury: _____

_____

Chief Complaints (location, descriptors, aggravating and easing factors): _____

_____

_____

_____

_____

Prior Functional Level: _____

_____

Functional Deficits/Tolerances: _____

_____

_____

Previous Therapy/Diagnosis Tests: _____

_____

PMH: _____

_____

Meds: _____

Sport/Job: _____ Currently Working: Yes / No

_____ Status: _____

Dominance: _____

Other: _____

_____

Current Functional Limitations/Objective Measures

Appearance/Posture/Gait: _____

_____

Sensation/Reflexes: _____

AROM: _____

_____

_____

Repetitive Movement Testing: _____

MMT: _____

_____

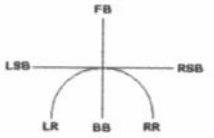
_____

Key
☐ Tender
O Sore
X Stiff
S Spasm

Palpation: _____

_____

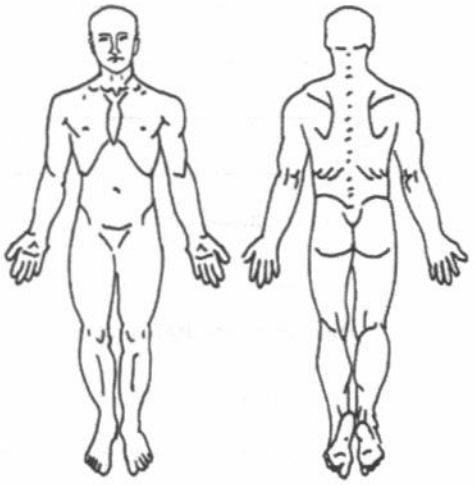
_____



Special Tests Performed: _____

_____

_____



Functional Tool Score: _____ Pain Scale Score: _____

Flexibility/Joint Play: _____

_____

Treatment: _____

_____

_____

Assessment: Findings/Precautions/Rehab Potential

Problem List:

1. _____
2. _____
3. _____
4. _____

Goals:

1. _____
2. _____
3. _____
4. _____

Plan: Frequency/Treatment Progression

_____

_____

_____

Therapist Signature