Physical Therapy Initial Evaluation Form

Patient Information

Patient Name

Date of Birth

Evaluation Date

Phone Number

Gender

Referring Physician

Subjective

Chief Complaint

History of Present Illness/Injury

Medical History / Medications

Patient Goals

Objective Assessment

Observation/Posture

Range of Motion (ROM)

Strength

Special Tests

Other Findings

Assessment

PT Assessment/Diagnosis

Plan

Treatment Plan/Recommendations

Frequency & Duration

Therapist Name