

Patient# _____ Provider _____

PHYSICAL THERAPY INITIAL EVALUATION FORM

PATIENT INFORMATION

DATE _____

NAME _____ (LAST) _____ (FIRST) _____ OCCUPATION _____

BIRTHDATE _____ AGE _____ HEIGHT _____ WEIGHT _____ lbs

HOME/CELL PHONE _____ EMPLOYER _____

CURRENTLY EMPLOYED? YES NO MODIFIED

REHAB INFORMATION

1. CHIEF COMPLAINT/AILMENT/INJURY _____

2. DATE OF INJURY _____ DATE OF SURGERY _____

3. BRIEFLY DESCRIBE HOW YOU WERE INJURED

4. HAVE YOU RECEIVED THERAPY FOR THIS CONDITION? YES NO WHEN? _____

HOW MANY VISITS? _____

5. HAS YOUR CONDITION BEEN GETTING: WORSE SAME BETTER

6. ARE YOUR SYMPTOMS: CONSTANT OR INTERMITTENT

7. MARK THE NUMBER THAT BEST CORRESPONDS TO YOUR PAIN:

AT BEST:	0	1	2	3	4	5	6	7	8	9	10 (EXCRUCIATING PAIN)
AT WORST:	0	1	2	3	4	5	6	7	8	9	10 (EXCRUCIATING PAIN)

8. WHAT DECREASES/MAKES YOUR CONDITION BETTER? (MARK ALL THAT APPLY)

BENDING	MOVEMENT	REST	BETTER IN AM
SITTING	STANDING	HEAT	BETTER AS DAY PROGRESSES
RIISING	WALKING	ICE	BETTER IN PM
CHANGING POSITIONS	LYING	MEDICATION	N/A. CAST JUST REMOVED

9. WHAT INCREASES/MAKES YOUR CONDITION WORSE? (MARK ALL THAT APPLY)

BENDING	MOVEMENT	REST	SNEEZE
SITTING	STANDING	STAIRS	DEEP BREATH
RIISING	WALKING	COUGH	MEDICATION
PROLONGED POSITIONING	LYING	WORSE IN AM	WORSE IN PM
WORSE AS DAY PROGRESSES	N/A. CAST JUST REMOVED		

10. PREVIOUS MEDICAL INTERVENTION (MARK ALL THAT APPLY)

X-RAY MRI CATSCAN INJECTIONS OTHER _____

Physical Therapy Evaluation Form Template

CH Cherryholmes

A red circular graphic with a gradient, appearing as a partial circle or a stylized arrow pointing to the right, located to the right of the author's name.

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