

# Physical Therapy Evaluation

## Patient Information:

Name:

Date of Birth:

Gender:

Address:

Phone:

Email:

## Emergency Contact:

Name:

Phone:

## Medical History:

### Primary Care Physician:

Name:

Phone:

### Referring Physician (if applicable):

Name:

Phone:

### Medical Conditions:

### Surgeries/Procedures:

### Medications:

**Allergies:**

**Presenting Problem:**

**Chief Complaint:**

**Onset:**

**Location:**

**Duration:**

**Aggravating/Alleviating Factors:**

**Previous Treatment:**

**Functional Assessment:**

**Activities of Daily Living (ADLs):**

**Work/Recreational Activities:**

**Physical Examination:**

**Range of Motion (ROM):**

**Strength:**

**Posture:**

**Gait Analysis:**

**Assessment:**

**Diagnosis/Impressions:**

**Plan of Care:**

**Goals:**

**Interventions:**

**Frequency/Duration:**

**Home Exercise Program (HEP):**

**Follow-up:**