# [COMPANY NAME]
## Outpatient Physical Therapy Evaluation

Phone: (___)_________ • Fax: (___)_________

| **Patient Name:** | **Physician Name:** |
|---|---|
| **Diagnosis:** | **Date of Evaluation:** |
| **Medications/Allergies/Precautions:** | **Date of Onset:** |
| **Past Medical History** | |
| | |
| | |
| **Subjective:** | |
| | |
| | |
| | |
| | |

### Physical Assessment

**Speech:**____________________**Vision:**______________________**Hearing:**_____________________**Cognition:**______________________________

**Nutritional Screening:** Appearance: Well-Nourished ☐ YES ☐ NO Well-Hydrated ☐ YES ☐ NO
Recent weight: Loss Gain Amount ___________________
Special Diet: ____________________________________________

**Vitals:**______________________________________________________________________________
______________________________________________________________________________

**Pain:**______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Posture/Body Mechanics:**_______________________________________________________________
______________________________________________________________________________

**Gait:**______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Palpation:**__________________________________________________________________________
______________________________________________________________________________

**Skin/Edema**:________________________________________________________________________
______________________________________________________________________________

**Sensation:**__________________________________________________________________________
______________________________________________________________________________

**Neurological Exam:**____________________________________________________________________
______________________________________________________________________________

**Special Tests:**________________________________________________________________________
______________________________________________________________________________

**ROM:** ______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

**Strength MMT)**: ______________________________________________

______________________________________________

______________________________________________

______________________________________________

**Initial Treatment**: ______________________________________________

______________________________________________

## Assessment: ______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

**Rehab Potential:** _______ **Excellent** _______**Good** _______**Fair** **Barriers to Learning**: ______________________________

**Short-Term Goals**: ______________________________________________

______________________________________________

______________________________________________

**Long-Term Goals**: ______________________________________________

______________________________________________

______________________________________________

## Plan of Treatment:

____Manual Therapy
____Neuromuscular Re-education
____ADL Training
____Gait Training
____Prosthetic Training
____Therapeutic Exercise
____Stretching
____Pt./Family Education
____Soft Tissue Mobilization
____Home Exercise Program
____Balance Training
____Lumbopelvic Strengthening
____Traction Lumbar/Cervical
____Functional Activity
____Modalities as Indicated
____Will update and/or modify goals/P.O.C. as needed

Patient understands diagnosis/prognosis and consents to treatment plan and goals: ___Yes ___No

**Frequency:** __________________ **Duration:** __________________

I certify that I have examined the patient and physical therapy is necessary. The patient is under my care and the plan will be reviewed every 30 days or more often if the patient's conditions required.

________________ ________________________________ ________________ ________________________________

Date Therapist's signature Date Physician's signature

Revised: _________