[COMPANY NAME]
Inpatient Physical Therapy Evaluation

Patient Name: _____ Physician Name: _____
Diagnosis: _____ Date of Eval: _____
Precautions: _____ Onset Date: _____
PT Orders: _____
Past Medical History: _____
_____
Patient/Family Goals: _____
Previous Level of Function/Social Environment (living arrangements, equipment, etc.): _____
_____

Physical Assessment

Speech: □ WNL □ Impaired **Vision**: □ WNL □ Impaired **Hearing**: □ WNL □ Impaired

ROM: _____

Strength: _____

Transfers: □ Independent □ SBA □ Minimal Assist □ Moderate Assist □ Maximum Assist □ Total

Bed Mobility: □ Independent □ SBA □ Minimal Assist □ Moderate Assist □ Maximum Assist □ Total

Balance: Sitting Static □ Good+/- □ Fair +/- □ Poor +/- **Dynamic** □ Good+/- □ Fair +/- □ Poor +/-
Standing Static □ Good +/- □ Fair +/- □ Poor +/- **Dynamic** □ Good +/- □ Fair +/- □ Poor +/-

Gait: _____
_____

Sensation: □ Intact □ Impaired □ Absent
Skin: _____
Endurance: □ Good □ Fair □ Poor
Pain Level/Precipitating Factors/Aggravating Factors: _____
Barriers to Learning: _____

Rehab Potential: □ Good □ Fair □ Poor

Assessment: _____
_____
_____.
_____

Goals:

- Patient will perform a home exercise program with _____ assist □ in _____ days or □ by discharge.
- Patient will perform functional transfers with _____ assist □ in _____ days or □ by discharge.
- Patient will ambulate ____ feet □ with a □ without assistive device and _____ assist □ in____ days or □ by DC.

Additional Goals:_____
_____

Treatment Plan:

□ Therapeutic Exercise □ Transfer Training □ Gait Training □ Endurance & Balance Activities
□ Modalities as Indicated □ Home Exercise Program □ Manual Therapy □ Education □ _____

Frequency/Duration: PT □ Twice a day □ Once a day □ Mon.-Fri. □ Until Discharge □ Until Goals Met

_____ _____ _____ _____ _____ _____
PT Signature Date Time Physician Signature Date Time

Revised: _____