Physical Therapy Outpatient Evaluation and Treatment Form

Patient Information

Patient Name:	Date of Birth:	Date of Evaluation:
Referring Physician:	Diagnosis / ICD-10:	Onset / Surgery Date:

Subjective Assessment

Chief Complaint / History of Present Illness:
Prior Level of Function:
Patient Goals:

Objective Examination

Vitals & Physical Findings

Blood Pressure:	Heart Rate:	Pain Level (0-10):
Posture / Observation:		

Range of Motion (ROM) & Strength (MMT)

Joint / Motion	Left ROM (Active/Passive)	Right ROM (Active/Passive)	Left Strength (MMT)	Right Strength (MMT)
e.g., Shoulder Flexion				
e.g., Knee Flexion				

Functional Mobility & Balance

Gait Assessment:
Balance (Static/Dynamic):
Transfers / Transitional Movements:

Clinical Assessment & Plan of Care

Clinical Impression / Rehab Potential:

Short-Term Goals (STG):   Long-Term Goals (LTG):

Treatment Frequency & Interventions

Frequency (e.g., 2x/week):	Duration (e.g., 6 weeks):
Planned Interventions: Therapeutic Exercise Yes/No/Details | Manual Therapy Yes/No/Details | Neuromuscular Re-education Yes/No/Details Modalities (e.g., Ultrasound, E-Stim): Home Exercise Program (HEP) Issued:	

Signatures

Physical Therapist Signature:	Date / Time: