INITIAL THERAPY EVALUATION

Name:	ID:	Diagnosis	Date
Job Title	**Employer**	**Work Status**	**Surgery Date**

SUBJECTIVE

History/Symptoms:

PAIN LEVEL CURRENT WORST BEST

HAND DOMINANCE

Patient Goals:

PMHx / Meds:

Contraindications / Precautions:

***** ***** *****

OBJECTIVE

ROM and Strength

Motion/Muscle						
AROM						
PROM						
MMT/Strength						

Palpation

Flexibility

Posture/Body Mechanics

Sensation

Gait

Balance

Special Tests	+/-	Functional Capability

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INITIAL THERAPY EVALUATION

Name ______________________ Date____________

OTHER OBJECTIVE FINDINGS:	TREATMENT

BILLING (Document unit count for each)

____Evaluation ____Manual Therapy ____Therapeutic Exercises ____Therapeutic Activities ____Neuromuscular Re-Education	____Community/Work Reintergration-Training ____Body Mechanics/Postural Training-Education ____Self-Care/ADLs /Home Management Training ____Gait Training ____Ultrasound	____ ____________ ____ ____________ ____ ____________

ASSESSMENT / PROBLEM LIST

Affecting , ,
Affecting , ,
Affecting , ,
Affecting , ,
Affecting , ,
Rehabilitation Potential: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

GOALS

Short Term Goals	Weeks	Long Term Goals	Weeks
Pt will have improved			
Pt will have improved			
Pt will have improved			
Pt will have improved			

PLAN OF CARE

☐ Manual Therapy ☐ Therapeutic Exercises ☐ Therapeutic Activities ☐ Neuromuscular Re-Education ☐ Gait Training ☐ Electrical Stimulation ☐ Ultrasound ☐ Cryotherapy ☐ Heat	☐ Home Exercise Program Instruction ☐ Body Mechanics Training / Education ☐ Postural Training / Education ☐ Functional Task Training (RTW Specific) ☐ Transfer Training ☐ Balance Training ☐ ________ ☐ ________ ☐ ________
Frequency	Patient will be seen times per week , for weeks.

____
Therapist Signature

I certify the need for these services furnished under this plan of treatment while under my care.

____
Physician Signature and Date

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