
Physical Therapy Assessment Form PDF

Patient Information

- Patient Name: _____
- Date of Birth: _____
- Gender: Male Female Other
- Contact Number: _____
- Emergency Contact: _____

Medical History

- Previous Injuries: _____
- Current Medications: _____
- Allergies: _____
- Surgical History: _____

Assessment Details

- Date of Assessment: _____
- Referring Physician: _____
- Reason for Referral: _____

Physical Examination

- Pain Scale (0-10): _____
- Affected Area(s): _____
- Range of Motion: _____
- Strength Testing: _____
- Functional Assessment:
 - Walking: Normal Altered
 - Stairs: Normal Difficulty

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- Sitting to Standing: Normal Difficulty

Treatment Plan

- Goals: _____
- Planned Interventions: _____
- Frequency of Sessions: _____

Therapist Notes

- Observations: _____
- Progression Recommendations: _____