# Physical Therapy Assessment Sheet

**Patient Details**

- Name: ________________________________
- DOB: _________________________________
- Gender: [ ] Male [ ] Female [ ] Prefer not to say
- Phone: ________________________________

**Health Background**

- Known Conditions: _______________________
- Medication: ____________________________
- Allergic Reactions: _______________________
- Past Physiotherapy Treatments: ______________

**Today's Evaluation**

- Date: _________________________________
- Assessment Reason: _______________________
- Pain Level (1-10): _______________________

**Examination**

- Mobility Assessment:
    - Full Range
    - Restricted
- Muscle Strength: ________________________
- Posture Analysis: _______________________

**Therapy Objectives**

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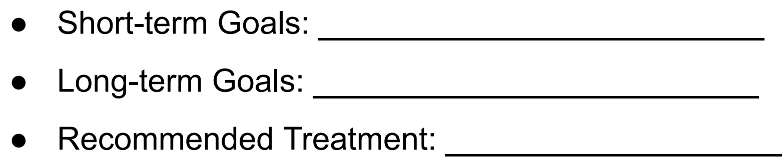

- Short-term Goals: ___________________________
- Long-term Goals: ___________________________
- Recommended Treatment: ____________________

**Physiotherapist's Remarks**

- Initial Findings: _____________________________
- Additional Comments: ________________________

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