Patient Assessment Form Physiotherapy

Patient Information

- **Full Name: ______________________________**
- **Age: ______________________________**
- **Gender: ______________________________**
- **Contact Number: ______________________________**

Medical History

- **Past Injuries: ______________________________**
- **Current Condition: ______________________________**
- **Pain Scale (1-10): ______________________________**

Assessment

- **Physical Mobility: ______________________________**
- **Strength Assessment: ______________________________**
- **Balance and Coordination: ______________________________**
- **Range of Motion: ______________________________**

Therapy Goals

- **Short-Term Goals: ______________________________**
- **Long-Term Goals: ______________________________**

Physiotherapist's Notes

- **Observations: ______________________________**
- **Recommendations: ______________________________**

Signature Section

- **Physiotherapist's Name: ______________________________**

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- **Date:** ______________________________

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