Company Name

PHYSICAL THERAPY EVALUATION

Patient Name	PT #	Date
Diagnosis		Time In: _____ Initials: _____ Time Out: _____ Initials: _____

LEFT			PART				RIGHT	FUNCTIONAL SUMMARY / ADL'S
SPAS SYN	STR	ROM			ROM	STR	SPAS SYN	GRADE: U - Unable (asst. impractical) A - Ass't's (Prac. or 1 person) S - Supervised (Verbal inst. only) I - Independent NE - Not Evaluated
			SCAP	Elev.				
				Depress				
				Protract				
				Retract				Dresses self
			SH	Flex				Feeds self
				Ext				Bathes self
				Abd				Sitti balan
				Add				Bed mobility
				I. Rot				Bowel/Bla er functi
				E. Rot				Ge in and o of tub/shower
			ELBOW	Flex				
				Ext				
			WRIST	Flex				**G EV UATION:**
				Ext				
				Sup				
				Pron				
			HIP	Flex				
				Ext				Climb Stairs
				Abd				Climb Steps
				Add				Architectural Barriers
				I. Rot				
				E. Rot				
			KNEE	F				
				Ext				*Comments:*
			ANKLE	Dorsi-				
				Pl. Flex				
				nver				
				r				
				Flex				
				xt				
				ot				
				Flex				
				Ext				
				Rot				

LIMITATIONS OF HAND AND FOOT:	Homebound Status:
Other:	

CONCLUSION: *(Mark)* ☐ Treatment ☐ Trial Program ☐ Treatment not indicated

PT. GOALS AND PLANS:

COMMUNICATION WITH M.D./AGENCY:

INITIAL TREATMENT:

Patient Name _____ **Signature** _____ **Date** _____

Clinician's Name_____ **Signature** _____ **Date** _____