McLAREN FLINT
Flint, Michigan
PHYSICAL THERAPY
INITIAL EVALUATION

Date of Service: _____ / _____ / _____

Patient Name: _____

Referring Doctor: _____

Database:

Patient Age: _____ Sex: ☐ Female ☐ Male

Diagnosis: _____

Past Medical History/Complicating Factors: _____

Past Surgical History: _____

Medications: _____

History of Present Illness: _____

Current Level of Function: _____

Prior Level of Function: _____

Social Living Situation: _____

Occupation: _____

Past Treatment for Current Condition: _____

Subjective:

Patient's Goals: _____

Pain Scale: On the scale of 0 to 10, with 10 being the worst, patient rates pain at _____.

Pain Description: _____

Onset: _____

Mechanism: _____

Alleviates Pain: _____

Provokes Pain: _____

Sleep Pattern: _____

Objective:

Orientation/Mentation: _____

Sensation: _____

PT.

MR.#/P.M.

DR.

Observation: _____

Posture: _____

Palpation: _____

Gait: _____

Range of Motion: _____

Left: _____

Right: _____

Strength: _____

Special Tests: _____

Treatment Rendered: _____

Assessment:

Clinical Impression: _____

Optimal Outcomes Tool Score (Medicare only): _____

The patient tolerated today's evaluation _____.

The patient will require skill PT for the following problem list and current functional limitations: _____

_____

The patient has _____ potential to meet the following goals:

Functional Short-Term Goals (to be achieved in _____ week(s): _____

_____

Functional Long-Term Goals (to be achieved by discharge): _____

_____

The above goals were reviewed and agreed upon with the patient.

Long-Term Prognosis: _____

Plan of Care:

The patient will be seen _____ times per week for _____ week(s) for treatment consistent of: _____

Thank you for this referral.

PT.

MR.#/P.M.

DR.