PT/OT INITIAL EVALUATION REPORT

Today's Date: __________________ Insurance Company: __________________________________

Patient Name: ____ Patient ID #: __________________________

Date of Birth / Age: ___________________ Date Of Injury: _____ / _____ / _____ Date Of Surgery: _____ / _____ / _____

ICD-9 Code(s): _________________________ Diagnosis: ____

Referring Physician: ____ Referring Physician ID #: ________________________

Therapy Office: ____ Discipline: PT / OT

OBJECTIVE FINDINGS

Involved Region: Left / Right / N/A

Strength (0-5)

Motion	Grade

Range of Motion

Motion	PROM	AROM

How / Where Injury Occurred:

Work Related? ☐ Yes ☐ No

Pertinent History:

Pain: Pain Scale: */10* Nature: constant / intermittent / localized / radiating

Functional Deficits / Additional Information:

Specific Treatment Plan:

Treatment Goals:

Projected Frequency / Duration of Treatment

Therapist Signature: **Printed Therapist Name and License #:**

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