



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)

Range of Motion

Motion	Grade	Motion	PROM	AROM

How / Where Injury Occurred:

Work Related? Yes No

Pertinent History:

Pain: Pain Scale: //0 Nature: constant / intermittent / localized / radiating

Functional Deficits / Additional Information:

Specific Treatment Plan:

Treatment Goals:

Projected Frequency / Duration of Treatment

Visits Requested:

Therapist Signature:

Printed Therapist Name and License #: