



# 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-10 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: //0 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 #: