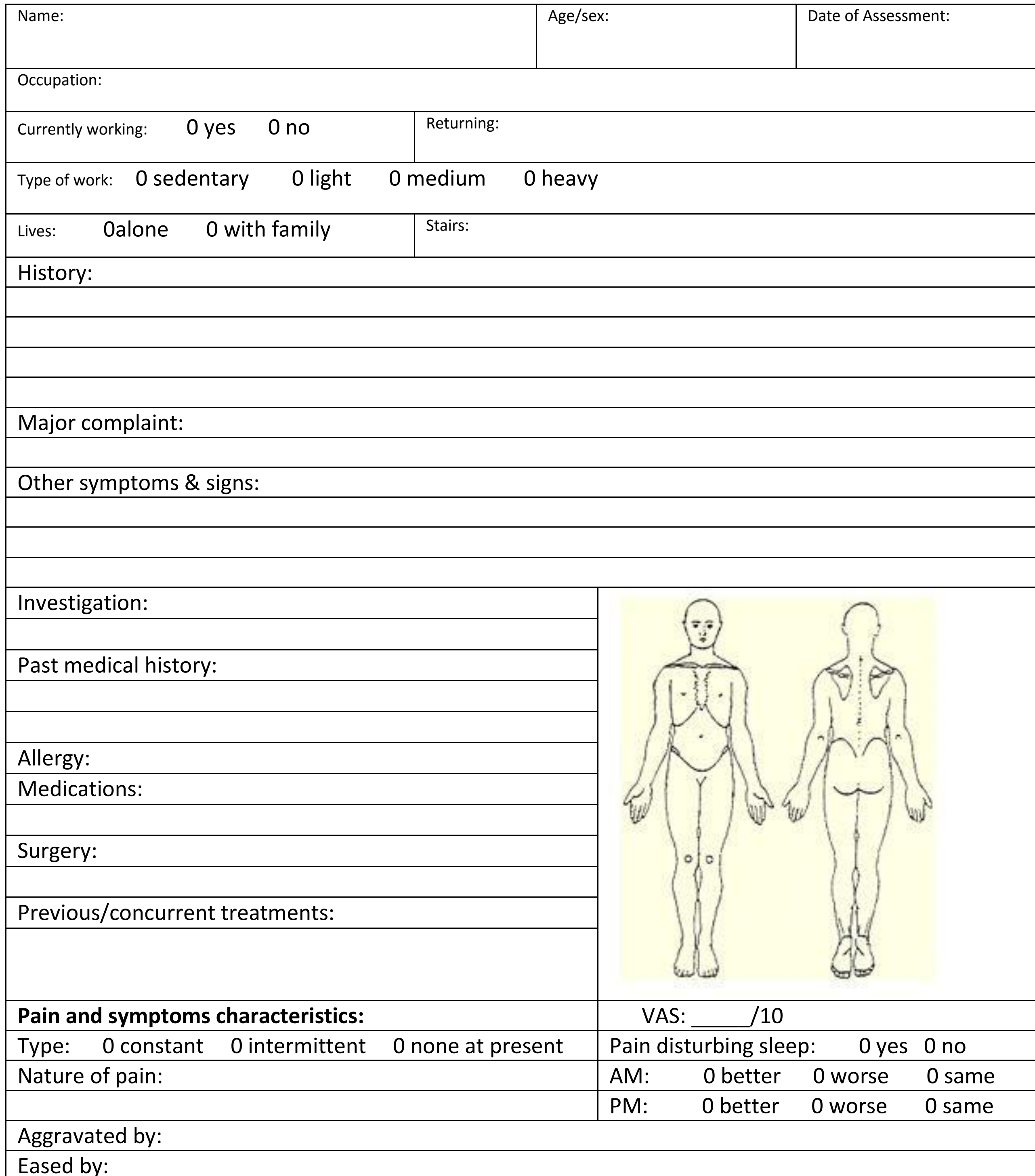
PHYSIOTHERAPY ASSESSMENT



Name:	Age/sex:	Date of Assessment:
Occupation:		
Currently working: 0 yes 0 no	Returning:	
Type of work: 0 sedentary 0 light 0 medium 0 heavy		
Lives: 0alone 0 with family	Stairs:	

History:
Major complaint:
Other symptoms & signs:

Investigation:	
Past medical history:	
Allergy:	
Medications:	
Surgery:	
Previous/concurrent treatments:	
Pain and symptoms characteristics:	VAS: _____/10
Type: 0 constant 0 intermittent 0 none at present	Pain disturbing sleep: 0 yes 0 no
Nature of pain:	AM: 0 better 0 worse 0 same
	PM: 0 better 0 worse 0 same
Aggravated by:	
Eased by:	

Observation/posture/gait:

Name:
Tenderness:
Soft tissue tightness:
ROM:
MMT:
Neural signs:
Special tests:
Other findings:

Analysis:		
Short term goals:		
Long term goals:		
Initial treatment plan:		
Care and treatments discussed with the client: 0 yes 0 no		
Name of the therapist:	Signature:	Date: