

Home Physical Therapy Assessment Form

Patient Information

Name

Date of Birth

Phone

Address

Emergency Contact

Referral Information

Referral Source

Diagnosis

Medical History

Relevant Medical History

Current Medications

Assessment

Mobility Status

Balance

Pain (location, severity)

Strength Assessment

Range of Motion

Home Environment

Home Safety Concerns

Assistive Devices/Equipment

Goals

Short Term Goals

Long Term Goals

Plan of Care

Plan

Frequency/Duration of Visits

Therapist Name/Signature

Date

