Manual Therapy Evaluation Checklist

Date:

Patient Name:

Therapist Name:

Subjective Information

Reason for Visit / Chief Complaint:

Pain Description (location, intensity, duration, type):

Objective Assessment

Test/Observation	Findings
Posture	
Range of Motion	
Muscle Strength	
Palpation	
Joint Mobility	
Special Tests	

Manual Therapy Techniques

Technique	Area Treated	Response/Effect

Pain Assessment

☐ None

- [ ] Mild
- [ ] Moderate
- [ ] Severe

Pain Scale (0-10):

Assessment & Plan

Summary/Assessment:

Treatment Plan/Recommendations: