Sports Injury Physical Therapy Evaluation

Patient Name

Date

DOB

Sport

Referring Physician

Injury Date

Subjective

Chief Complaint

History of Present Injury

Pain Scale (0-10)

Location of Pain

Type of Pain

Previous Treatments

Objective

Observation/Posture

Range of Motion (ROM)

Strength

Special Tests

Palpation

Functional Assessment

Assessment

Clinical Impression

Rehabilitation Potential

Plan

Treatment Plan

Goals

Frequency/Duration

Therapist Name

Signature

Date