Worker's Compensation Physical Therapy Initial Evaluation

Patient Information

Patient Name

Date of Birth

Date of Evaluation

Claim Number

Employer

Insurance Carrier

Referring Physician

Subjective

History of Present Illness/Injury

Mechanism of Injury

Date of Injury

Previous Treatment

Current Symptoms

Pain Level (0-10)

Aggravating/Relieving Factors

Functional Limitations

Objective

Observation/Posture

Range of Motion

Strength

Palpation

Special Tests

Neurological

Other Relevant Findings

Assessment

Summary/Clinical Impression

Problem List

Plan

Goals

Treatment Plan

Frequency/Duration

Home Exercise Program

Therapist Name

Signature

Date