Aquatic Physical Therapy Initial Evaluation Form

Patient Information

Full Name

Date of Birth

Date of Evaluation

Contact Number

Referring Physician

Diagnosis/Reason for Referral

Medical History

Relevant Medical Conditions

Current Medications

Allergies

Previous Surgeries/Injuries

Subjective Information

Chief Complaint

Pain Level (0-10)

Pain Description/Location

Mobility/Functional Limitations

Objective Assessment

Posture/Alignment

Range of Motion

Strength

Balance/Coordination

Gait

Aquatic Assessment

Comfort in Water

Ability to Enter/Exit Pool

Buoyancy & Support Needs

Swimming/Movement Skills

Precautions in Aquatic Environment

Assessment/Diagnosis

Clinical Impression

Goals

Short Term Goals

Long Term Goals

Plan of Care

Recommended Aquatic Interventions

Frequency/Duration

Progression Criteria

Therapist Information

Evaluator Name

Signature

Date