OUTPATIENT PHYSICAL THERAPY – INITIAL EVALUATION – LOWER QUADRANT

Patient Name: _____ Age: _____ Date: _____

Medical Diagnosis: _____ Onset: _____

Surgical Procedure: _____ Date: _____

Rehab Diagnosis: _____ Start of Care Date: _____

Referred to PT for: _____ Physician: _____

Precautions: _____

Because domestic violence is known to be a common problem, I now ask each patient about violence in their lives. Is this a problem for you? _____

S: History of Present Illness: _____

Tests: _____

Medications: _____

Social History: _____

PMHx: _____

PSHx: _____

Appearance/Behavior: _____

Range of Motion:

Knee Flexion	R _____	L _____		Knee Extension	R _____	L _____	
Hip Flexion	R _____	L _____		Ankle Dorisflexion	R _____	L _____	
Hip Extension	R _____	L _____		Ankle Plantarflexion	R _____	L _____	
Hip Abduction	R _____	L _____		Ankle Eversion	R _____	L _____	
Hip IR	R _____	L _____		Ankle Inversion	R _____	L _____	
Hip ER	R _____	L _____		Other: _____			

Strength:

Knee Flexion	R _____	L _____		Knee Extension	R _____	L _____	
Hip Flexion	R _____	L _____		Ankle Dorisflexion	R _____	L _____	
Hip Extension	R _____	L _____		Ankle Plantarflexion	R _____	L _____	
Hip Abduction	R _____	L _____		Ankle Eversion	R _____	L _____	
Hip Adduction	R _____	L _____		Ankle Inversion	R _____	L _____	
Hip IR	R _____	L _____					
Hip ER	R _____	L _____					

Other: _____

Special Tests:

IT Band Tightness	R _____	L _____		Hamstring Tightness	R _____	L _____	
Valgus/Varus Test	R _____	L _____		McMurray Test	R _____	L _____	
Appley's Compr/Distract	R _____	L _____		Ant/Post Drawer Test	R _____	L _____	
Chondromalacia Test	R _____	L _____					

Other: _____

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PATIENT LABEL

MR.PTEVAL

SVPOD-152 (Rev. 4/05)

Pain: On a scale of 0 - 10 (10 = worst possible), pain rating is: _____ /10 Average _____ /10 Highest

Palpation: _____

Posture: _____

Gait: _____

Transfers: _____

Balance: _____

Neurological Status: _____

Treatment Received: Instructed patient in the folowing exercises:

☐ INITIATED PATIENT/FAMILY EDUCATION STANDARD
☐ INITIAL EVALUATION COMPLETED
☐ ISSUED WRITTEN EXERCISE INSTRUCTIONS

Patient's Goals: _____

Discharge Plans:
- ☐ Return to work.
- ☐ Return to prior to injury functional level.

Functional Strengths/Limitations:
- ☐ Motivated
- ☐ Chr Health Problems
- ☐ Other
- ☐ Anxious
- ☐ Learning Difficulties

Problem List:
- ☐ Decreased Range of Motion
- ☐ Increased pain ☐ Edema
- ☐ Decreased Functional Level
- ☐ Lacks Knowledge Re: Home Ex. Program
- ☐ Antalgic Gait
- ☐ _____
- ☐ _____

Long Term Goals: Target date _____ weeks
- ☐ Independent with Home Exercise Program
- ☐ Increases _____ ROM to _____ degrees
- ☐ Return to work within _____
- ☐ Decrease pain to _____ /10 in _____
- ☐ Improve _____ strength to _____ /5
- ☐ Able to amb with normal gait pattern with least restrictive device.
- ☐ _____
- ☐ _____

Long Term Goals: Target date _____ weeks
- ☐ Decrease pain to _____ /10 in _____
- ☐ Increases _____ ROM to _____ degrees
- ☐ Improve _____ strength to _____ /5
- ☐ Able to perform daily activities for _____ minutes with/without _____ pain
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Patient: ☐ Agrees ☐ Disagrees with goals

Treatment Plan and Procedures:
- ☐ Therapeutic Exercise _____
- ☐ Modalities _____
- ☐ Stretches _____
- ☐ _____

Frequency: _____
Duration: _____
Rehab Potential:
- ☐ Poor ☐ Good
- ☐ Fair

Recommendations/Comments: _____

_____

_____

_____

_____ , Licensed Physical Therapist Date: _____