ABC PHYSICAL THERAPY PC
ABSOLUTE BEST CARE

INTIAL EVALUATION

Patient: _____ Date of service: _____
Physician: _____ Age/sex: _____
Diagnosis: _____ Chief complaint: _____
History: _____

Past medical history: _____
Radiographs/tests: _____
Postural eval: _____
Initial observations: _____
Palpation: _____

Range of motion:

	Right		Left	

Strength:

Movement	Right	Left

Special tests/provocation: _____
Sensory/ reflex testing: _____
Plan of Care: _____

_____
Physical Therapist

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