

**THERAPY FACILITY NAME ADDRESS**

**Phone: Fax: Address**

**PHYSICAL THERAPY RE-EVALUATION**

**Date of Visit:\_\_\_\_\_\_\_\_\_\_\_\_\_ Total Visits Attended to Date: ­­­­\_\_\_\_\_\_\_\_\_\_**

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| **Patient Name:** | **DOB:** MM/DD/YYYY **Gender:** M/F |
| **Diagnoses:** | **Surgery Type/Date:** |
| **Referring Physician:** | **DOI/Onset date:** |
| **Patient Occupation:** | **Employer:** |
| **Current Work Status:** | **Last Day Worked:** |
| **PDL Current:** | **PDL Required for Job:** |

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| **SUBJECTIVE** |
| **Reason for Re-evaluation:** | **Changes in Co-morbidities/Medications:** |
| **Pain Location/Behavior:** | **Pain Rating (VAS):****Current:****Best:****Worst:** |
| **Contraindications/Precautions:** | **Current Chief Complaint(s):** |
| **Current Functional Limitations (incl. job specific):** | **Updated Outcome Score:** |
| **Other Subjective Comments:** |

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| **OBJECTIVE** |
| **Observations:** | **Posture:** |
| **Palpation (specify location and findings):** | **Joint Mobility (specify location & findings):** |
| **Special Tests (Orthopedic) – Specify test & result:** | **Special Tests (Balance/Neuro) – Specify test & result:** |
| **Blood Pressure Resting:****Blood Pressure w/exertion:** | **Heart Rate Resting:****Heart Rate w/exertion:** |
| **Gait assessment (incl. any assistive device used):** | **Functional Tests (specify test & result):** |
| **Sensation:** | **Other Objective Findings/Comments:** |

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| **MOVEMENT:****Joint & Motion** |

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| **AROM****(\* indicates painful)** | **PROM****(\*indicates painful)** | **STRENGTH****(\*indicates painful)** |

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| i.e. Shoulder Flexion**\*IE = Measure at Eval** | **R** | **@IE** | **L** | **@IE** | **R** | **@IE** | **L** | **@IE** | **R** | **@IE** | **L** | **@IE** |
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| **Dynamometer Testing** |  |  |  |  |  |  |
| **Materials Handling Tests (Job Specific):** |
| **Non-Materials Handling Tests (Job Specific):** |

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| **ASSESSMENT** |
| **Summary of treatment provided and progress:****Barriers to Rehab:****Current Impairments:****Job Specific Functional Deficits:****Additional Treatment Recommended (Incl. frequency, duration and clinical rationale):****Rehab Potential:** |

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| **GOALS (Job Specific – Include Return to Work Goals)** |
| **Goal** | **Short/Long****Term** | **Time Frame** | **Met / Unmet / % Met** |
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| **PLAN** |
| **Continued Treatment recommended?** | **Recommended Frequency/Duration to continue:** |
| **Total # of Visits Authorized:****Total # of Visits Attended:** | **Surgical Restrictions/Precautions:** |
| **Planned Services:** |
| **Plan Comments:** |

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| **Treating Therapist Name/License #:** |
| **Treating Therapist Signature:** |

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| **Physician Signature:** | **Date:** |
| **Physician Name:** |  |
| **Physician Comments/Recommendations:** |