CLIENT EVALUATION INTAKE INFORMATION

DATE: __________________
CLIENT NAME: ________________________________
STUDENT THERAPIST(S): __________________________

MEDICAL HISTORY

PRIMARY DIAGNOSIS AND REASON FOR SEEKING TREATMENT (CHIEF COMPLAINT):
______________________________________________________________________________
______________________________________________________________________________
ONSET DATE:
______________________________________________________________________________

HISTORY OF PRESENT ILLNESS (include initial symptoms & how has it changed):
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

PREVIOUS REHABILITATION OR THERAPIES/TYPES OF THERAPIES, PLACE OF SERVICE, AND WHEN THEY WERE RECEIVED (include medical tests that have been done):
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

SOCIAL HISTORY

LIVING SITUATION: ________________________________

ANY ADAPTIVE EQUIPMENT: ________________________________

WORK/SCHOOL STATUS:
______________________________________________________________________________
______________________________________________________________________________

ACTIVITY LEVEL & FREQUENCY: ________________________________

ARE YOU CURRENTLY DOING A HOME EXERCISE PROGRAM? DESCRIBE IT:
______________________________________________________________________________
______________________________________________________________________________

TRANSPORTATION (Drive or Provider, Company or Friend/Family and what is their number):
______________________________________________________________________________
______________________________________________________________________________
HOBBIES/LEISURE INTERESTS:

PERSONAL GOALS & ISSUES YOU HOPE TO ADDRESS:

EVALUATION FINDINGS:

PAIN RATING:

GENERAL OBSERVATIONS (include posture):

MOBILITY (include Level of Independence and Assistance/Device in this section):
  - Bed Mobility:
  - Transfers:
  - Locomotion:
  - Comments/Descriptors(PLEASE FILL THIS SECTION IN):

ROM (ACTIVE / PASSIVE):

MUSCLE TONE/REFLEXES:

SENSATION:

VISION:

BALANCE:

COORDINATION:

ENDURANCE:
OTHER:

ASSESSMENT:

▪ PROGNOSIS:

▪ LTG (end of the semester):

▪ STG:

PLAN:

__________________________________________  Signature  ____________________________________________  Date