**County Hospital**

**Physical Therapy Department**
**Evaluation**

NAME _____ AGE_____ ADMISSION DATE_____
DOCTOR _____ MEDICAL RECORDS #_____
DATE OF EVAL _____ REFERRAL DATE_____
DIAGNOSIS _____
DATE OF ONSET/CHANGE IN CONDITION _____
HISTORY:
Past Medical: _____
Prior P.T. & Home Program: _____
Functional Abilities: (prior/current) _____
Surgery/Procedures: _____
Medications/Precautions: _____

SUBJECTIVE: _____
_____

OBJECTIVE:
Current Mental Status:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Alertness: | Alert | ____ | Lethargic | ____ | Semi-comatose | ____ | Comatose | ____ | | | |
| Orientation: | Person | ____ | Place | ____ | Time | ____ | Confused | ____ | | | |
| Behavior: | Coop | ____ | Uncoop | ____ | Agitated | ____ | Combative | ____ | | | |
| Compliance: | Good | ____ | Fair | ____ | Unable | ____ | Unwilling | ____ | | | |
| Consistency: | Good | ____ | Moderate | ____ | Fair | ____ | Poor | ____ | | | |
| Communication: | ____ | Verbal | ____ | Appropriate | ____ | Inappropriate | ____ | Aphasic | | | |

Skin Condition: ____ Clear ____ Fragile ____ Dry Eccymosis: _____
Pain: _____ Sensation: _____
ROM: _____ Active _____ Passive _____ WNL _____ WFL Limitations: _____
_____
Strength: Gross strength _____ (0/5--5/5) Upper Extremities
_____ (0.5--5/5) Lower Extremities

Limitations _____
Bed Mobility: N/7 Transfers: N/7
(1) Up/down in bed _____ (1) Supine to sit _____
(2) Supine to sidelying _____ (2) Sit to stand _____
Neuro: Balance SIT _____ (N/5) STANDING _____ (N/5)

AMBULATION ACTIVITIES:
Device: _____ Walker _____ St Cane _____ Q Cane _____ Crutches _____ Other
Distance: _____ Assistance (N/7) _____
Gait Pattern: _____ 3 point step to _____ 3 point step through _____ 4 point
Weight Bearing Status: _____
Deviations: _____
Education: _____

ASSESSMENT:
(PROBLEM SUMMARY) _____
_____
_____
_____
_____
REHAB POTENTIAL: REHAB BARRIERS: