



Clinic name

Address · Phone · Licence no.

Physiotherapy initial assessment

Two pages: referral and history, pain, range of motion and strength, goals and plan.

Patient name _____ File no. _____ Date of birth _____
Phone _____ Date _____ Doctor _____

Referral and diagnosis

Referred by _____ Referral date _____
Medical diagnosis _____ Physiotherapy diagnosis _____
Date of onset or injury _____ Occupation and activity _____

Affected side ☐ Right ☐ Left ☐ Both

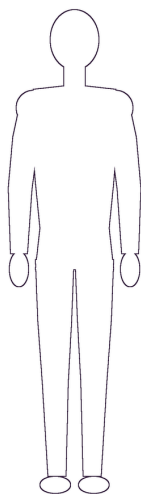
History

Presenting complaint _____

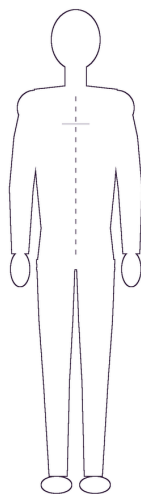
Mechanism of injury _____ Previous episodes and treatment _____
Medical and surgical history _____ Current medications _____
Imaging and investigations _____ What the patient wants back _____

Red flags screened ☐ Yes, none ☐ Yes, present (note) ☐ Not screened

Pain



Front



Back

Shade where it hurts; add an arrow if it spreads.

Pain scale: 0 no pain, 10 worst imaginable

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pain now (0–10) _____

Worst this week _____

Least this week _____

Type of pain _____

Worse with _____

Eased by _____

Pattern over 24 hours _____

Numbness or pins and needles _____

Range of motion

Joint	Movement	Side	Active (°)	Passive (°)	Normal (°)	Note (pain, end feel)

Strength

Muscle group	Side	Grade (0–5)	Muscle group	Side	Grade (0–5)

Functional tests

Test or activity	Result	Note

Goals (measurable)

Term	Goal	How it is measured	By
Short term			
Short term			
Long term			
Long term			

Plan

Sessions per week Planned sessions

Re-assessment date Home exercise programme

☐ Exercise therapy ☐ Manual therapy ☐ Electrotherapy

☐ Ultrasound ☐ Heat or cold ☐ Taping

☐ Dry needling ☐ Patient education ☐ Other:

Consent to treat

The assessment, the plan and what the treatment involves were explained to me, and I could ask questions. I agree to start treatment and know I can stop at any time.

Patient or guardian signature

Physiotherapist name and signature

Date

Physiotherapy progress report

Patient name File no. Date of birth

Phone Date Doctor

To referring doctor Diagnosis

Period from To

Sessions attended Of sessions planned

Pain: then and now

	At assessment	Now
Pain now (0–10)		
Worst this week		

Range of motion: then and now

Joint	Movement	Side	At assessment (°)	Now (°)	Normal (°)

Functional change

Test or activity	At assessment	Now

Goals

Goal	Met / partly / not met	Note

Plan

Decision ☐ Continue ☐ Modify ☐ Discharge

Further sessions What changes in the plan

Recommendation to the referring doctor

Physiotherapist name and signature

Date

In Medicolize this document lives on the patient file: medicolize.com