

RETURNING PATIENT EVALUATION



Patient's Name: _____ Last Visit Date: _____

Today's Date: _____ Return To Dr. Date: _____

1. Have you had any changes in your physical condition or medical history since your last visit to our facility?
 Yes No If you answered yes, provide a brief description below.

2. Since you were last here, have you undergone any treatments or testing such as: X-ray, MRI, EMG, CT Scan, etc.?
 Yes No If yes, please provide a brief description.

3. Since your last visit, have there been any changes in medications you're taking? Yes No If yes, please list them.

4. Have you been received any additional medical diagnoses since your last visit with us? Yes No If yes, please indicate any new diagnoses.

5. Have you changed physicians since you were last here? Yes No If yes, please provide your current physician's name and contact information.

6. Please indicate any other changes or information you feel is important for your Physical Therapist to be aware of.

System Review – Clinic Use Only

	<u>Not Impaired</u>	<u>Impaired</u>
Cardiovascular / Pulmonary System (HR, RR, BP, Edema) _____	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary System (Integrity, Scar Formation, Color) _____	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal System (Gross Strength, ROM, Symmetry) _____	<input type="checkbox"/>	<input type="checkbox"/>
Neuromuscular System (Balance, Gait, Locomotion, Transfers, Motor Function) _____	<input type="checkbox"/>	<input type="checkbox"/>
Communication System (Affect, Cognition, Learning Style) _____	<input type="checkbox"/>	<input type="checkbox"/>
Other significant objective tests and measurable findings.		
Plan: <input type="checkbox"/> PT Eval <input type="checkbox"/> Referral: _____ <input type="checkbox"/> Other: _____	Staff Initials: _____	Date: _____