Client Physiotherapy Assessment Form

Client Information

Client Name: _____ Date: _____ Therapist: _____

Date of Birth: _____ Phone: _____

Email: _____ Emergency Contact & Number: _____

Insurance Provider: _____ Policy/Plan #: _____

Certificate/Member ID #: _____

Pain Rating & Description

Current pain level (0–10): ■0 ■1 ■2 ■3 ■4 ■5 ■6 ■7 ■8 ■9 ■10

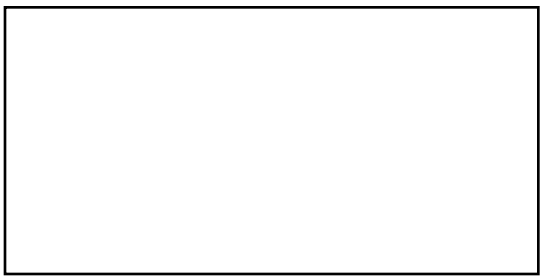
Worst pain in the past week (0–10): ■0 ■1 ■2 ■3 ■4 ■5 ■6 ■7 ■8 ■9 ■10

Best pain in the past week (0–10): ■0 ■1 ■2 ■3 ■4 ■5 ■6 ■7 ■8 ■9 ■10

Pain pattern: ■ Constant ■ Intermittent ■ Worse in morning ■ Worse at night

Pain description (sharp, dull, throbbing, burning, etc.): _____

Pain area diagram (mark X where it hurts):



General Health & Lifestyle

General health: ■ Excellent ■ Good ■ Fair ■ Poor

Sleep quality: ■ Good ■ Fair ■ Poor

Do you smoke or vape? ■ Yes ■ No

Do you currently exercise? ■ Yes ■ No If yes, what type/how often? _____

Medical conditions (e.g., diabetes, heart, arthritis, etc.): _____

1. Presenting Concern

Area of injury or pain: _____

How long have you had this issue? _____

Was there any trauma or specific incident that caused it? (Describe mechanism of injury): _____

2. Symptom Details

What activities or movements make it worse? _____

What activities or positions do NOT cause pain or make it feel better? _____

Do you experience numbness, tingling, or 'pins and needles'? ■ Yes ■ No If yes, where? _____

3. Functional Limitations

At home: _____

At work: _____

During recreation/sport/play: _____

4. Work and Lifestyle

What do you do for work? _____

What tasks or physical demands are involved? _____

Do you live in a house, apartment, or other? _____

Do you require help with any tasks at home? ■ Yes ■ No If yes, which ones? _____

5. Past and Current Management

Have you had any previous injuries in this area? ■ Yes ■ No Describe: _____

Have you tried other treatments or exercises for this issue? ■ Yes ■ No What kind? _____

Have you used any of the following? ■ Ice ■ Heat ■ Medication ■ Bracing ■ Other: _____

6. Medical History & Objective Overview (for clinician notes)

Do you take regular medications? ■ Yes ■ No If yes, which ones? _____

Have you had imaging/tests (X-ray, MRI, CT, ultrasound)? ■ Yes ■ No If yes, when and where? _____

Have you seen your doctor or another healthcare professional for this issue? ■ Yes ■ No If yes, who and what was recommende

Range of motion limitations: _____

Strength in functional positions: _____

Observations/posture/gait: _____

7. Consent and Communication Preferences

Preferred method of contact: ■ Phone ■ Email ■ Text

Do you consent to physiotherapy assessment and treatment? ■ Yes ■ No

Would you like home exercise programs by: ■ Email ■ Printed

8. Goals

In your own words, what do you hope to achieve from physiotherapy?