Physiotherapy Assessment Template

History of Presenting Condition (HOPC)

Describe the history of presenting condition, including the mechanism and date of injury, management since injury, etc.

1.
2.
3.

Describe factors that aggravate and ease the pain.

1.
2.
3.

Describe the pain over the duration of 24 hours.

Radiology

List any radiology assessment and their findings that have been undertaken for this patient's presenting complaint/injury.

1.
2.
3.

Past Medical History (PMH)

List existing and past medical conditions, e.g., osteoporosis, stroke, high blood pressure, surgeries, each with a brief description and how they are managing each condition, e.g. Amlodipine 5mg QD.

1.
2.
3.

Mention any allergies.

1.
2.
3.

Social History

Mention relevant social history like lifestyle factors, living arrangements, support network, tobacco/alcohol use, etc.

1.
2.
3.

Mention family medical history of disease that may be relevant to their presenting condition or may impact their response to therapy.

1.
2.
3.

Summarise employment status, occupation, hours work, physical/mental intensity of job, etc.

Goals

Short-term physiotherapy goals & time frame for achieving these goals

1.
2.
3.

Long-term physiotherapy goals & time frame for achieving these goals

1.
2.
3.

Objective

List all physical observations and examinations completed, along with their findings.

1.
2.
3.

Treatment

List all physical observations and examinations completed, along with their findings.

1.
2.
3.

List all hands-on treatment provided throughout the session, for example, Mobilisation: Gr II PA R) C5/6 2x30secs, Unilateral soft tissue massage upper L) calf, etc.

1.
2.
3.

List all active therapy treatments provided throughout the session, for example, 3x10 single-leg calf raises, 3x10 L) ankle knee to walls, etc

1.
2.
3.

List home exercise program [HEP] provided

1.
2.
3.

Assessment

Summarise the assessment and state the diagnosis based on subjective and objective findings.

Summarise the assessment and state differential diagnosis based on subjective and objective findings.

Summarise their progress towards their stated goals.

State any barriers affecting progress.

Plan

Brief summary of the clinical plan until the next appointment.

Timeline of next review.

Likely therapy I will provide at our next appointment.

Referrals to other professionals that need to occur or the patient will attend.

Letters, phone calls or communication the treating therapist will do before next session.