PHYSICAL THERAPY EVALUATION AND THERAPY PLAN OF CARE

Patient Name: _____ Date: _____ Time In: ____ : ____ Time Out: ____ : ____

MR#: _____ DOB: _____ Male: ☐ Female: ☐

Physician Name: _____ Physician Phone #: _____

SIGNIFICANT MEDICAL HISTORY / CLINICAL FINDINGS

Primary Dx: _____ Onset Date: _____ Rehab. Dx: _____

Secondary Dx: _____

Past Medical History: _____

Prior PT Services: _____

Prognosis: ☐ Poor ☐ Guarded ☐ Fair ☐ Good

Mental Status: ☐ Alert ☐ Oriented (☐ Time ☐ Place ☐ Person) ☐ Disoriented ☐ Forgetful

Other: _____

Vitals: Pulse: ____ /min BP: ____ / ____ RR: ____ /min Shortness of Breath when Ambulate > 20 ft: ☐ Yes ☐ No

Pulse: ____ /min BP: ____ / ____ RR: ____ /min

Pain Assessment: Pain Severity Level: 0 1 2 3 4 5 6 7 8 9 10 Location: _____

Aggravated by: _____ Relieved by: _____

Type: ☐ Aching ☐ Burning ☐ Radiating ☐ Referred ☐ Spasmodic ☐ Constant ☐ Agitated ☐ Intermittent

Pain management plan established with patient: ☐ Yes ☐ No

Pulmonary Assessment: _____

Musculoskeletal Assessment:		**Muscle Strength**		**Range of Motion**	
	Movements	Left	Right	Left	Right
Shoulder	Flexion/Extension				
	Abduction/Adduction				
Elbow	Flexion/Extension				
Wrist	Flexion/Extension				
Fingers	Flexion/Extension				
Hip	Flexion/Extension				
	Abduction/Adduction				
Knee	Flexion/Extension				
Ankle	Flexion/Extension				
Foot	Inversion/Eversion				
Trunk	Flexion/Extension/Rotation				

Muscle Tone: ☐ Normal ☐ Abnormal Specify: _____

Balance Impairment: **Sitting** Static: ____ Dynamic: ____ **Standing** Static: ____ Dynamic: ____

Coordination: _____ **Sensation:** _____

Functional Assessment:	**Current Functional Status**								**Prior Functional Status**							
	Ind	Sup	CG	Min	Mod	Max	Dep	NA	Ind	Sup	CG	Min	Mod	Max	Dep	NA
Bed mobility																
Supine to sit																
Transfer in/out of bed																
Bed to chair																
Sit to stand																
Toilet/commode																
Shower/tub transfer																
Orthosis/prosthesis																

Patient Name: _____ Date: _____ MR#: _____

Ambulation	Ind	Sup	VC	CG	Min	Mod	Max	A. Device	Distance	Prior Status
Indoors	☐	☐	☐	☐	☐	☐	☐			
Outdoors	☐	☐	☐	☐	☐	☐	☐			
# of stairs	☐	☐	☐	☐	☐	☐	☐			
Gait Deviations	☐	☐	☐	☐	☐	☐	☐			

Home Bound Status:

☐ patient needs taxing effort to leave home ☐ unable to walk to elevator or street ☐ bed bound
☐ medical restrictions ☐ residual weakness ☐ requires assistance for all activities
☐ confusion unable to leave home alone ☐ severe SOB

Home Assessment: _____

Current Functional Problem	Functional Goals and Outcome	# of Visits

Patient/Caregiver Stated Goals: _____

Falls Assessment and Intervention:

Timed Up and Go Test Score: ____ sec Tinnetti Test Score: ____ /28 Functional Reach Test Score: ____ inch

Has the patient fallen in past 12 months or since the last assessment? ☐ Yes ☐ No

Does the patient need falls prevention program intervention? ☐ Yes ☐ No

Intervention and Plan of Care:

☐ Functional Gait Training ☐ Transfer Training ☐ Progressive Balance & Coordination Training
☐ Progressive Therapeutic Exercise ☐ ROM Exercise ☐ Establish and Upgrade Home Exercise Program
☐ Falls Prevention Management ☐ Cardiopulmonary Rehabilitation ☐ Caregiver Education
☐ Orthotic/Prosthetic Training ☐ NDT ☐ Postural Training

Others: _____

Skilled Treatment Provided this Visit: _____

Communication of Care with: ☐ MD ☐ RN ☐ Coordinator ☐ OT ☐ ST

Name: _____

Eval + _____ **visits** **Next Visit Date:** _____

Frequency/Duration: _____

Plan of Care discussed with Patient/Caregiver ☐ Yes ☐ No Patient Signature: _____

Therapist Name: _____ Therapist Signature: _____ Date: _____

Physician Notified: _____ Physician Signature: _____

to: