



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: WNL

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: WNL **Sensation:** WNL

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
Transfers Ambulation		8 ↓

Patient/Caregiver Stated Goals: ⊕ w/ all ADLs & Ambulation

Falls Assessment and Intervention:

Timed Up and Go Test Score: _____ sec Tinetti Test Score: _____ /28 Functional Reach Test Score: 0 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 + 8 _____ visits Next Visit Date: _____

Frequency/Duration: 2x/1w/4w

Plan of Care discussed with Patient/Caregiver <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Patient Signature: _____
Therapist Name: <u>Christopher Evangelista</u>	Therapist Signature: <u>[Signature]</u> Date: _____
Physician Notified: _____	Physician Signature: _____

HOME EXERCISE PROGRAM

Sitting

2 sets x 10 reps
each side

If exercise causes pain, dizziness or shortness of breath - **STOP**

Do Exercises 1-2 times a day.
Do Not Hold Breath!

Patient Name

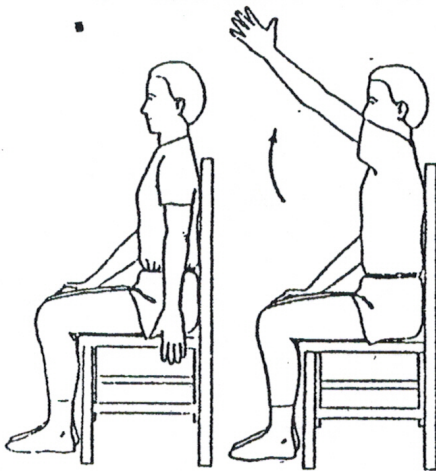
CHRIS

PT Name

CASE MANAGER:

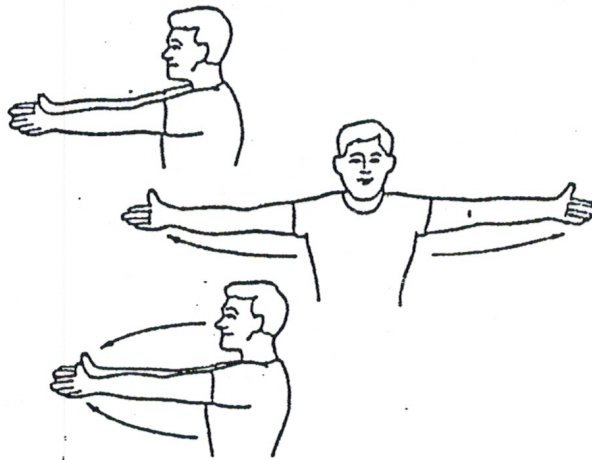
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Date



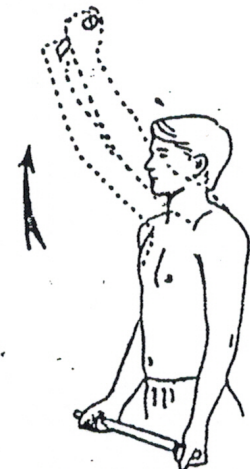
Bring ___ arm forward and overhead toward ceiling. Touch top of head. Reach up again to ceiling. Lower arm down to side.

___ Alternate arms
___ Repetitions ___ Sets.



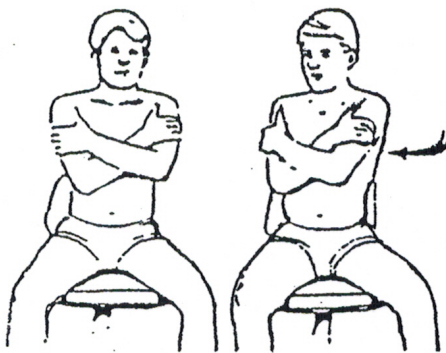
Reach forward, palms facing each other. Spread arms apart, bring together.

___ Repetitions ___ Sets.
___ Try with palms turned up.



Holding wand with hands underneath, slowly reach up overhead. Then lower.

___ Repetitions ___ Sets.



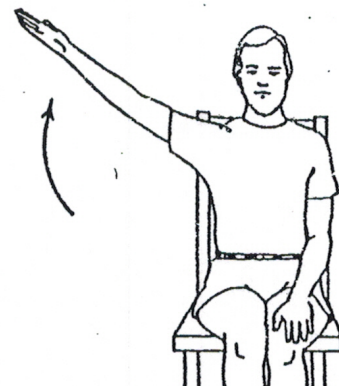
Cross arms in front of body. Then twist from side to side.

___ Repetitions ___ Sets.
Try same exercise with arms at eye level.



Arms at side. Palms forward. Reach up and out to side bringing arm overhead toward ceiling. Touch top of head. Reach up again toward ceiling, then lower arm.

___ Arm. ___ Both arms ___ Repetitions ___ Sets.



Tap foot on floor slowly.
2 Repetitions 10 Sets.
Move foot forward for more stretch.
Circle ankles clockwise and counter clockwise.



Lift heel off floor slowly, then lower. Move foot back for better stretch.

2 Repetitions 10 Sets.



Slowly lift knee up toward ceiling. Lift toes at same time. Lower to floor, heel first.

2 Repetitions 10 Sets



Slowly kick foot up toward ceiling straightening knee. Pull toes toward you, then lower.

2 Repetitions 10 Sets

Both legs

PATIENT NAME: _____ ID#: _____ AGENCY: _____ MONTH: _____ YEAR: _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
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NURSE	AIDE	PHYSICAL THERAPIST	OCCUPATIONAL THERAPIST	SPEECH THERAPIST
NAME:	NAME:	NAME: Chris	NAME:	NAME:
PHONE:	PHONE:	PHONE: 773-618-6592	PHONE:	PHONE:

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✓

HOME EXERCISE PROGRAM

Lying Down

If exercise causes pain, dizziness or shortness of breath - **STOP**

Do Exercises 2 times a day.
Do Not Hold Breath!

Patient Name _____

10th

PT Name _____

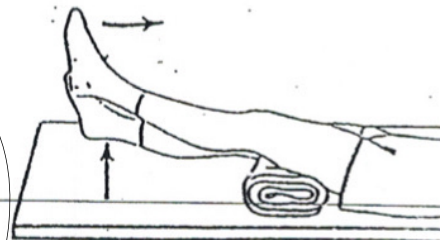
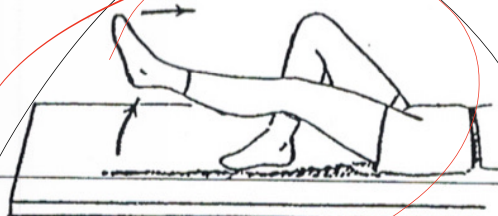
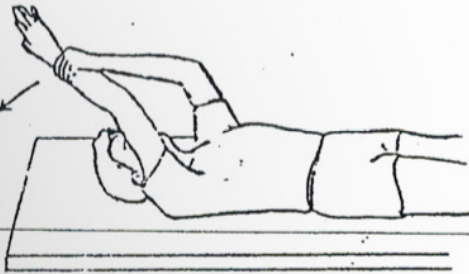
CASE MANAGER!

Date _____

Quad Sets: Tighten thigh muscle to make knee as stiff and straight as possible. HOLD _____ seconds. Relax. _____ Repetitions _____ Sets.

Glut Sets: Tighten buttock muscle and squeeze together. HOLD _____ seconds. Relax. _____ Repetitions _____ Sets.

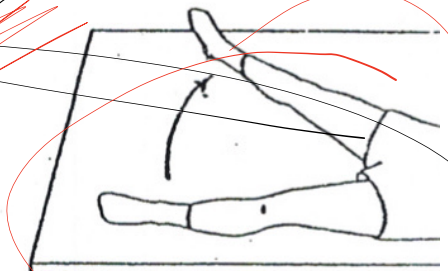
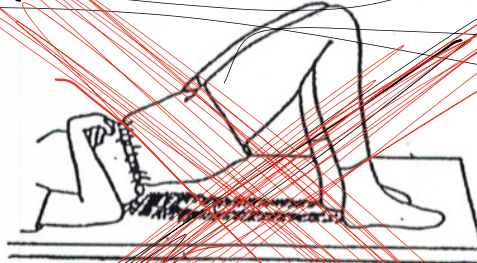
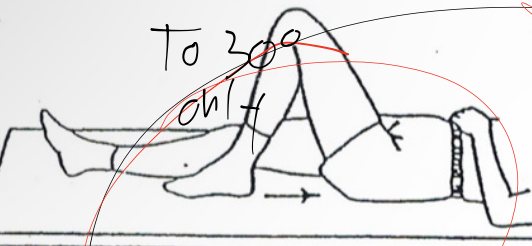
Ankle Pumps: Slowly move foot up toward head, then point foot down as much as possible. _____ Repetitions _____ Sets.
Then move foot in circle _____ times one direction _____ times other direction _____ Repetitions _____ Sets.



Grasp _____ wrist with _____ hand, then bring both arms up overhead as far as comfortably possible. HOLD _____ seconds, then lower. _____ Repetitions _____ Sets.
_____ Try with hands clasped

Do Quad Set, then lift leg 2 inches off bed, HOLD 2 seconds, then lower down. Relax, repeat. Pull toes toward head on lifting. 1 Leg _____ Both legs
10 Repetitions 2 Sets.

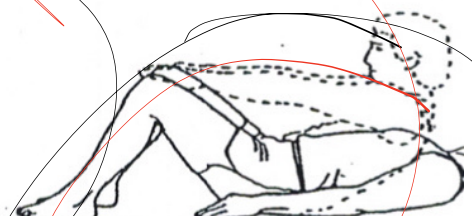
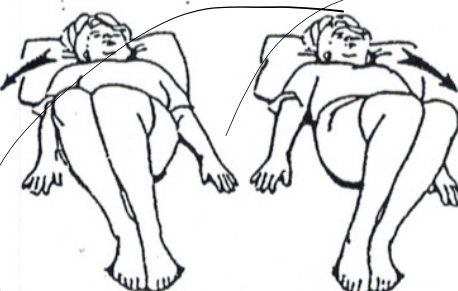
Place blanket/towel roll under knee straighten knee to lift foot off bed. Hold _____ seconds. Pull toes toward head. _____ Repetitions _____ Sets.



Legs flat on bed. Slide both foot up toward buttock as far as comfortably possible. HOLD 2 seconds, then slide back down straight. _____ Repeat with other leg. 10 Repetitions 2 Sets.

Legs bent, feet flat on bed. Lift buttock up off bed as much as possible. HOLD 2 seconds, then lower back down. _____ Help with arms on bed if necessary. 10 Repetitions 2 Sets.

Legs flat, slide _____ leg out to side. keep foot pointed to ceiling. HOLD _____ seconds, pull back in. _____ Alternate other leg 10 Repetitions 2 Sets.



Pull _____ leg up toward chest, help with hands if necessary, then straighten out knee as much as comfortably possible. HOLD _____ seconds. _____ Alternate with other leg. _____ Repetitions _____ Sets.

Legs bent, then bring knees over to one side as far as comfortably possible, then back to other side. 10 Repetitions 2 Sets.
Try with hands clasped and arms outstretched toward ceiling, bring arms one direction and

Legs bent, tighten stomach. Lift head shoulders off mattress reaching toward with arms, then lower back down. **DO NOT HOLD BREATH!** 10 Repetitions 2 Sets.

