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
- [ ] medical restrictions
- [ ] confusion unable to leave home alone
- [ ] unable to walk to elevator or street
- [ ] residual weakness
- [ ] severe SOB
- [ ] bed bound
- [ ] requires assistance for all activities

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
- [ ] Progressive Therapeutic Exercise
- [ ] Falls Prevention Management
- [ ] Orthotic/Prosthetic Training
- [ ] Transfer Training
- [ ] ROM Exercise
- [ ] Cardiopulmonary Rehabilitation
- [ ] NDT
- [ ] Progressive Balance & Coordination Training
- [ ] Establish and Upgrade Home Exercise Program
- [ ] Caregiver Education
- [ ] 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/w 4w

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

Therapist Name: _____ Therapist Signature: _____ Date: _____

Physician Notified: _____ Physician Signature: _____

to: