



## 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    Tinetti 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 +** \_\_\_\_\_ **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: \_\_\_\_\_