

## PHYSICAL THERAPY EVALUATION AND THERAPY PLAN OF CARE

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:	Patient Name:								Time In::				Time Out::					
SIGNIFICANT MEDICAL HISTORY / CLINICAL FINDINGS  Primary Dx:									DOB: Male: Female					ale:				
Primary Dx:	Physician Nam								Physician Phone #:									
Past Modical History:				SIGI	NIFICA	M TA	EDICA	L HIS	TORY	/ CLIN	IICAL F	INDING	iS					
Past Medical History:	Primary Dx:					Onset	Date:_		Rehab. Dx:									
Past Medical History:	Secondary Dx:																	
Poor																		
Mental Status:	Prior PT Service	es:																
Dither:	Prognosis:	Poor			arde	d		Fair		G	ood							
Dither:	Mental Status:	Alert			Oriente	d (	Tim	- ne □	Place	 □ P€	erson)	Г	Disc	riented	d	ПЕ	oraetf	ul
Action											,					ш.	o. go	
Pulse:									Sho	rtnaes	of Bro	ath who	n Amh	ulata :	> 20 ft		Vas	
Pain Assessment:   Pain Severity Level:   0   1   2   3   4   5   6   7   8   9   10										111633	o or bre	alli Wile	II AIIIL	Julate 2	- 20 II	• Ш	162	140
Relieved by:										7 0	•	10 1						
No																		
Pain management plan established with patient:									_					_		_	_	
Musculoske stal Assessment:	Type: A	ching B	urning		Radia	ting	Re	terred		Spasm	nodic	Cor	nstant	/	Agitate	d _	Interr	nittent
Musculoske stal Assessment:	Pain managem	ent plan esta	blished	d with	patien	t:	Ye	s		No								
Movements	Pulmonary As	sessment: _																
Movements	Musculoskele	etal Assessm	ent:			Muscle Strength							Range of Motion					
Shoulder   Flexion/Extension																		
Elbow   Flexion/Extension	Shoulder		sion							9						•		
Wrist   Flexion/Extension   Florider   Flexion/Extension   Flexion/Extension/Rotation   Flexion/Extensio		Abduction/Ad	duction	า														
Fingers   Flexion/Extension	Elbow	Flexion/Exten	sion															
Hip Flexion/Extension	Wrist	Flexion/Exten	sion															
Abduction/Adduction	Fingers	Flexion/Exten	sion															
Flexion/Extension	Hip	Flexion/Exten	sion															
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  Functional Assessment: Normal Status Prior Functional Status  Bed mobility Supine to sit Transfer in/out of bed Bed to chair Sit to stand Toilet/commode		Abduction/Adduction																
Foot	Knee	Flexion/Extension																
	Ankle	Flexion/Exten	sion															
Muscle Tone: Normal Abnormal Specify:    Salance Impairment:   Sitting   Static:   Dynamic:   Standing   Static:   Dynamic:	Foot	Inversion/Eve	rsion															
Salance Impairment:  Sitting Static: Dynamic: Standing Static: Dynamic: Dynamic: Dynamic: Sensation:    Functional Assessment:   Current Functional Status   Prior Functional Status	Trunk	Flexion/Exten	sion/R	otation														
Salance Impairment:  Sitting Static: Dynamic: Standing Static: Dynamic: Dynamic: Dynamic: Sensation:    Functional Assessment:   Current Functional Status   Prior Functional Status	Muscle Tone:	Norn	nal		Abnorn	nal	S	necify										
Functional Assessment:    Current Functional Status												handin.	_	Ctatio	_	D. a		
Functional Assessment:         Current Functional Status           Ind         Sup         CG         Min         Mod         Max         Dep         NA         Ind         Sup         CG         Min         Mod         Max         Dep         NA           Bed mobility         Image: CG mobility or color of the color of th	_			•								otandin	9	Static		_ Dyi	namic:	
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	Coordination:						_ 5	ensati	on:									
Bed mobility Supine to sit Transfer in/out of bed Bed to chair Sit to stand Toilet/commode	Functional A	ssessment:			Curre	nt Fund	tional	Status					Prio	r Funct	ional S	tatus		
Supine to sit  Transfer in/out of bed  Bed to chair  Sit to stand  Toilet/commode			Ind	Sup	CG	Min	Mod	Max	Dep	NA	Ind	Sup	CG	Min	Mod	Max	Dep	NA
Transfer in/out of bed  Bed to chair Sit to stand Toilet/commode	Bed mobility																	
Bed to chair Sit to stand Toilet/commode	Supine to sit																	
Sit to stand Toilet/commode	Transfer in/out	of bed																
Toilet/commode	Bed to chair																	
Shower/tub transfer																		
Orthosis/prosthesis																		

Patient Name:									Date:	MR#:	
Ambulation	Ind	Sup	VC	CG	Min	Mod	Max	A. Device	Distance	Prior Sta	atus
Indoors											
Outdoors											
# of stairs											
Gait Deviations											
Home Bound Status:											
patient needs taxing	effort	to lea	ve ho	me	u	nable	to wal	k to elevator o	r street	bed bound	
medical restrictions					_ re	esidua	al weak	ness		requires assistance	for all activities
confusion unable to I	eave	home	alone		s	evere	SOB				
Home Assessment:											
Current Functional Prob	lom					ınotio	nal Ga	als and Outco	mo		# of Visits
Current i unctional Frob	леш				1 (	inctio	iiai Gu	als and Outco	ille		# OI VISILS
Patient/Caregiver State	d Go	ale:									
Falls Assessment and I											<del></del> -
Timed Up and Go Test S				:	Tin	netti <sup>-</sup>	Test So	core: /2	8 Func	tional Reach Test Sco	ore: inch
Has the patient fallen in p											<u> </u>
Does the patient need fal								Ye			
Intervention and Plan o				0							
Functional Gait Traini			Г	☐ Trar	nsfer T	Γrainin	ıq		Progressive	Balance & Coordina	tion Training
Progressive Therapeu	_	xercis	e	_	И Ехе			[		nd Upgrade Home Ex	_
Falls Prevention Mana			Ē	Car	diopu	lmona	ry Reh	nabilitation	Caregiver E		
Orthotic/Prosthetic Ti	rainin	g		ַ מח [	-				Postural Tra	aining	
Others:											
Skilled Treatment Provi	ded t	his Vi	sit: _								
Therex (AROM in all plan	nes of	B LES)	, trans	fer tra	ining,	static/	dynan'	nic balance train	ing		
Communication of Care	with	: 🗌	MD	F	RN [	Со	ordina	tor OT	ST		
Name:											
Eval +								8	visits Ne	xt Visit Date:	
Frequency/Duration: 23	x/w 4v	V									
Plan of Care discussed	with F	atient	:/Care	giver	Y6	es 「	No	Patient Signat	ure:		
Therapist Name: Evange										Date:	
Physician Notified:								Physician Sign	nature:		