Abbey Home Health

Agency S.D.C. Date | **PT Evaluation Date**

PHYSICAL THERAPY EVALUATION

PATIENT DEMOGRAPHICS

Patient Name: (First, Middle, Last, Suffix) | Patient ID # | Certification Period From: To:

Patient Street Address | City | State | Zip | Patient Phone #

Medicare Number (including suffix, if any) | Medicaid Number | Social Security Number | Height | Weight | Birth Date | Gender ☐ M ☐ F

Primary Language Spoken | Interpreter Needed ☐ Yes ☐ No Non-Verbal ☐ Yes ☐ No ☐ Sign Language | Physician's Name | Physician's Phone

Principal Diagnosis | Surgical Procedure

Other Pertinent Diagnoses

Reason for Physical Therapy Referral | Patient has an able and willing caregiver ☐ Yes ☐ No

Medical History of Present Illness

Prior Functional Status

MUSCULOSKELETAL STATUS / PHYSICAL THERAPY ASSESSMENT

VITAL SIGNS (per HHA policy)

PULSE: ☐ Apical _____ (Reg) (Irreg) ☐ Radial _____ (Reg) (Irreg)
TEMP:_____ RESP._____
Height _____ Weight _____ ☐ Actual ☐ Stated
B/P Lying _____ Sitting _____ Standing _____
L _____
R _____
Current Weight Bearing Status _____

ADL's Independent | Req. Assistance | Dependent

	I	RA	D		I	RA	D		I	RA	D		I	RA	D
Grooming	☐	☐	☐	Bathing	☐	☐	☐	Ambulation/Locemetion	☐	☐	☐	Laundry	☐	☐	☐
Ability to Dress Upper Body	☐	☐	☐	Toileting	☐	☐	☐	Feeding or Eating	☐	☐	☐	Housekeeping	☐	☐	☐
Ability to Dress Lower Body	☐	☐	☐	Transferring	☐	☐	☐	Light Meal Preparation	☐	☐	☐	Shopping	☐	☐	☐
								Transportation	☐	☐	☐	Ability to Use Telephone	☐	☐	☐

Comments

POSTURE ☐ NO DEFICITS ☐ CURVATURE OF SPINE ☐ OTHER _____

RANGE OF MOTION/MOBILITY *UPPER EXTREMITIES* ☐ NO DEFICITS
☐ LIMITED: AREA %REDUCED

LOWER EXTREMITIES ☐ NO DEFICITS
☐ LIMITED: AREA %REDUCED

MUSCLE STRENGTH AGAINST GRAVITY *UPPER BODY* ☐ NO DEFICIT
FAIR ☐ L ☐ R DECREASED GRIP STRENGTH ☐ L ☐ R ATROPHY ☐ L ☐ R
POOR ☐ L ☐ R ABSENT ☐ L ☐ R
Comments

LOWER BODY ☐ NO DEFICIT
FAIR ☐ L ☐ R ABSENT ☐ L ☐ R
POOR ☐ L ☐ R ATROPHY ☐ L ☐ R
Comments

BALANCE
SITTING ☐ NO DEFICIT ☐ ALTERED Describe:_____
STANDING ☐ NO DEFICIT ☐ ALTERED Describe:_____
GAIT ☐ NO DEFICIT ☐ ALTERED Describe:_____ ☐ SHUFFLING ☐ UNSTEADY ☐ TREMORS
Comments

JOINTS ☐ NO DEFICIT ☐ ENLARGED ☐ WARM/RED ☐ PAINFUL ☐ STIFF
Comments

PROSTHETIC DEVICE/ADAPTIVE EQUIPMENT ☐ NONE
☐ CAST/SPLINT DUE TO: _____ ☐ CANE DUE TO: _____
☐ PROSTHESIS DUE TO: _____ ☐ WALKER DUE TO: _____
☐ ADAPTIVE DEVICE DUE TO:_____ ☐ OTHER:_____
Comments

BED MOBILITY ☐ NO DEFICIT ☐ ALTERED Describe: _____

TRANSFERS ☐ NO DEFICIT ☐ ASSISTED BY: _____ PERFORMANCE EFFECTED BY:_____
Comments

ENDURANCE ☐ NO DEFICIT ☐ EASILY FATIGUES ☐ EASILY SHORT OF BREATH ☐ LIMITED BY: _____
Comments

EMOTIONAL STATUS/BEHAVIORS WHICH MAY IMPACT PLAN OF TREATMENT ☐ NONE ☐ IDENTIFIED AS _____

HOME STRUCTURE/HOUSEHOLD BARRIERS THAT MAY IMPACT PLAN OF TREATMENT ☐ NONE ☐ IDENTIFIED AS _____

NEUROLOGICAL ☐ WNL _____
SENSATION ☐ WNL _____
PALPATION ☐ Not Tested Location: _____
SKIN CONDITION ☐ WNL _____
EDEMA ☐ WNL _____

Abbey Home Health

PHYSICAL THERAPY EVALUATION

PAIN

Frequency of Pain interfering with patient's activity or movement:

- ☐ 0- Patient has no pain or pain does not interfere with activity or movement
- ☐ 1 - Less often than daily
- ☐ 2 - Daily, but not constantly
- ☐ 3 - All of the time

Comments

PAIN PROFILE

Primary Site

Intensity: 0 1 2 3 4 5 6 7 8 9 10 (LOW … HIGH)

Current pain management & effectiveness:

☐ Pain Management Teaching to patient/family *(document below)*

Patient's pain goal: Progress toward pain goal:

☐ See Additional Pain Assessment/Documentation (per agency policy)
Refer to:

Additional Assessment Comments

HOMEBOUND ☐ NO ☐ YES

If YES, give reason:

ADDITIONAL SERVICES ☐ OT ☐ SLP ☐ MSS ☐ AIDE ☐ SN ☐ HME ☐ OTHER

PROBLEMS IDENTIFIED

PHYSICAL THERAPY ORDERS

Frequency of Physical Therapy Visit:

Other Services Ordered:

Assess/Perform/Instruct Pt/Cg:	A	P	I
☐ POSTURE TRAINING/EXERCISES	☐	☐	☐
☐ L. E. ROM EXERCISES	☐	☐	☐
☐ L. E. POSITIONING & BODY ALIGNMENT EXERCISES	☐	☐	☐
☐ U. E. ROM EXERCISES	☐	☐	☐
☐ U. E. POSITIONING & BODY ALIGNMENT EXERCISES	☐	☐	☐
☐ UPPER BODY MUSCLE STRENGTHENING EXERCISES	☐	☐	☐
☐ LOWER BODY MUSCLE STRENGTHENING EXERCISES	☐	☐	☐
☐ BALANCE EXERCISES/***SITTING***	☐	☐	☐
☐ BALANCE EXERCISES/***STANDING***	☐	☐	☐

Assess/Perform/Instruct Pt/Cg:	A	P	I
☐ GAIT TRAINING	☐	☐	☐
☐ JOINT MOBILITY PROGRAM	☐	☐	☐
☐ CAST CARE	☐	☐	☐
☐ PROSTHETIC DEVICE	☐	☐	☐
☐ ADAPTIVE DEVICE	☐	☐	☐
☐ CIRCULATDRY CHECKS AS APPLICABLE	☐	☐	☐
☐ BED MOBILITY	☐	☐	☐
☐ TRANSFER TECHNIQUES	☐	☐	☐
☐ ENDURANCE IMPROVEMENT/STRENGTH EXERCISES	☐	☐	☐
☐ OTHER	☐	☐	☐
☐ OTHER	☐	☐	☐

GOALS / REHABILITATION POTENTIAL / DISCHARGE PLANS

- ☐ The patient's safety will be enhanced throughout the home care service, as evidenced by _____ within _____ period of time.
- ☐ The patient/caregiver will verbalize understanding of (disease process) _____ and all aspects of associated care in _____.
- ☐ The patient's home environment will be clean & safe, as evidenced by _____ within _____ period of time.
- ☐ The patient's hygiene and personal care needs will be met this cert period with the assistance of the home health aide, as evidenced by _____ within _____ period of time.
- ☐ The patient will reach maximum functional potential, as evidenced by _____ within _____ period of time.
- ☐ The patient will have psycho/social needs met, as evidenced by _____ within _____ period of time.
- ☐ Patient/Caregiver's Expectations: _____
- ☐ Other: _____ within _____ period of time.
- ☐ Rehabilitation potential: _____

SPECIFIC PHYSICAL THERAPY GOALS

Short Term:

Long Term:

Discharge Plans

- ☐ Patient to be discharged when skilled care no longer needed ☐ Other (specify) _____
- ☐ Patient to be discharged to the care of: ☐ Self ☐ Caregiver ☐ Other: _____

Skilled Services provided this visit and Patient Response:

Patient Signature (optional per HHA policy & procedure):

Physical Therapist's Signature & Date of Verbal SOC Where Applicable:	**Time In** / **Time Out**	**HHA USE ONLY**	**Checked By** / **Date**	**Entered By** / **Date**	**Transmitted By** / **Date**

PATIENT NAME

PHYSICIAN'S SIGNATURE / DATE (optional per HHA policy & procedure)