FIRST HEALTH SYSTEMS

PHYSICAL THERAPY EVALUATION and TREATMENT PLAN

INSTRUCTIONS: This form must be completed by a licensed professional Physical Therapist. Refer to the back side of the form for Objective Data Tests and Scales.

PERTINENT BACKGROUND INFORMATION

Facility _____

Resident _____ Room No. _____ Admission date ___/___/___ D.O.B. ___/___/___

Medicare No. _____ ❑ Part A ❑ Part B Other insurance _____

Treatment diagnosis _____ ICD-9 code _____ Onset ___/___/___

MD referral and date _____ Date plan established ___/___/___

Prior level of function _____

Prior living situation/support system _____

Describe pertinent medical/social history and/or previous therapy provided: _____

MUSCLE STRENGTH/FUNCTIONAL ROM EVALUATION

	AREA	STRENGTH RIGHT	STRENGTH LEFT	ACTION	ROM RIGHT	ROM LEFT
UPPER EXTREMITIES	Shoulder			Flex/Extend		
				Abd./Add.		
				Int. rot./Ext. rot.		
	Elbow			Flex/Extend		
	Forearm			Sup./Pron.		
	Wrist			Flex/Extend		
	Fingers (Grip)			Flex/Extend		
LOWER EXTREMITIES	Hip			Flex/Extend		
				Abd./Add.		
				Int. rot./Ext. rot.		
	Knee			Flex/Extend		
	Ankle			Plant./Dors.		
	Foot			Inver./Ever.		

FUNCTIONAL INDEPENDENCE/BALANCE EVALUATION

	TASK		ASSIST GRADE	ASSISTIVE DEVICES/ COMMENTS
BED MOBILITY	Roll/turn			
	Sit/supine			
	Scoot/bridge			
TRANSFERS	Sit/stand			
	Bed/wheelchair			
	Toilet			
	Floor			
	Auto			
BALANCE	Sit	Static		
		Dynamic		
	Stand	Static		
		Dynamic		
W/C SKILLS	Propulsion			
	Weight shift			
	Foot rests			
	Brakes			

ADDITIONAL SKIN/MUSCLE EVALUATION CRITERIA

TRUNK/NECK/POSTURE _____

MUSCLE TONE _____

SPECIFIC DEFICITS _____

_____

PALPATION _____

SKIN CONDITION _____

EDEMA _____

REHAB POTENTIAL _____

PAIN: ❑ Intermittent ❑ Variable ❑ Constant

Intensity scale: 1 _____ 10

ADDITIONAL FUNCTIONAL EVALUATION CRITERIA

ENDURANCE _____

COGNITION: ❑ Alert ❑ Oriented x_____ ❑ Confused

❑ Comatose ❑ Agitated ❑ Lethargic

❑ Good judgement in regards to safety

❑ ST Memory ❑ LT Memory

❑ Follows _____ step commands

VISION _____ **HEARING** _____ **SPEECH** _____

PROPRIOCEPTION _____ **COORDINATION** _____

GAIT ANALYSIS

ASSIST _____ **DEVICE** _____

GAIT ANALYSIS _____

_____

WEIGHT BEARING STATUS _____ **LEG LENGTH** _____

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

FIRST HEALTH SYSTEMS

PHYSICAL THERAPY EVALUATION and TREATMENT PLAN

PHYSICAL THERAPY TREATMENT PLAN

SHORT TERM GOALS	Time Frame	LONG TERM GOALS	Time Frame	RESIDENT'S GOALS

❑ Gait training ❑ Balance training/Activities ❑ Functional mobility training ❑ Prosthetic training

❑ Evaluation ❑ Therapeutic exercise ❑ Cardio-pulmonary PT ❑ Establish rehab. nursing program

❑ Modalities _____ ❑ Other _____

Frequency and duration _____ Precautions _____

Equipment recommendations _____ Discharge plan _____

Signature and title of Physical Therapist _____ Date ____/____/____

OBJECTIVE DATA TESTS AND SCALES

MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH

GRADE	DESCRIPTION
5	Normal functional strength - against gravity - full resistance.
4	Good strength - against gravity with some resistance.
3	Fair strength - against gravity - no resistance - safety compromise.
2	Poor strength - unable to move against gravity.
1	Trace strength - slight muscle contraction - no motion.
0	Zero - no active muscle contraction.

FUNCTIONAL RANGE OF MOTION (ROM) SCALE

GRADE	DESCRIPTION
5	100% active functional motion.
4	75% active functional motion.
3	50% active functional motion.
2	25% active functional motion.
1	Less than 25%.

FUNCTIONAL INDEPENDENCE SCALE (BED MOBILITY, W/C, BALANCE, GAIT)

GRADE	DESCRIPTION
5	Physically able and does independently.
4	Verbal cue (VC) only needed.
3	Stand-by assist (SBA)–100 % patient effort.
2	Minimum assist (Min A)–75% patient effort.
1	Maximum assist (Max A)–25% - 50% patient effort.
0	Totally dependent–total care.

BALANCE SCALE (SITTING - STANDING)

GRADE	DESCRIPTION
5	Good balance responses bilaterally.
3	Deficit balance but able to support self–at risk for falls.
1	Poor balance–needs support.

AVERAGE RANGES OF JOINT MOTION (ROM)

AREA	ACTION/MOVEMENT			
Shoulder	Flex	158°	Extend	55°
	Abd	170°	Add.	50°
	Int. rot.	70°	Ext. rot.	90°
Elbow	Flex	145°	Ext.	0°
Forearm	Sup.	85°	Pron.	70°
Wrist	Flex	73°	Ext.	70°
Fingers	Flexall	90°	Ext.	0°
Hip	Flex	90° - 115°	Ext.	25°
	Abd.	45°	Add.	30°
	Int. rot.	45°	Ext. rot.	45°
Knee	Flex	135°	Ext.	10°
Ankle	Plant.	50°	Dors.	20°
Foot	Inv.	30°	Ever.	20°

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed