Aug. 24. 2010 11:41AM No. 1537 P. 4

Agency SOC Date: ☐ SOC ☐ Recert ☐ ROC

THERAPY EVALUATION

Patient Name: | PT Evaluation Date: | Record #: | Birth Date:

Physical Therapy Visit # _____ (optional per agency policy) | Combined Therapy Visit # _____ (optional per agency policy)

Reason for Physical Therapy Referral:

Prior Functional Status: | Other Pertinent Diagnoses/Medical History:

Physician's Name: | Physician's Phone #:

MUSCULOSKELETAL STATUS / PHYSICAL THERAPY ASSESSMENT

VITAL SIGNS (per agency 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 _____

ADLs Independent / Req. Assistance / Dependent

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

Comments

RANGE OF MOTION / MOBILITY

Joint/ Segment	Movement	Range	PROM Right	PROM Left	AROM Right	AROM Left
Elbow	Flexion	0-140				
	Hyperextension	0-0				
Forearm	Pronation	0-90				
	Supination	0-90				
Wrist	Extension	0-70				
	Flexion	0-70				
	Radial Deviation	0-70				
	Ulnar Deviation	0-70				
Shoulder	Flexion	0-180				
	Abduction	0-180				
	Other					
Hip	Flexion	0-120				
	Extension	0-25				
	Adduction	0-45				
	Abduction	0-45				
	Internal Rot.	0-45				
	External Rot.	0-45				
Knee	Flexion	0-120				
	Extension	0-15				
Ankle	Flexion	0-45				
	Extension	0-30				
Cervical Spine	Flexion	0-45				
	Hyperextension	0-45				
	Lateral Flexion	0-45				
	Rotation	0-45				

Comments

MUSCLE STRENGTH AGAINST GRAVITY

Strength Scale: 5 = WNL 4 = Good 3 = Fair 2 = Poor 1 = Trace 0 = Absent

☐ LUE: ☐5 ☐4 ☐3 ☐2 ☐1 ☐0 ☐ RUE: ☐5 ☐4 ☐3 ☐2 ☐1 ☐0

☐ LLE: ☐5 ☐4 ☐3 ☐2 ☐1 ☐0 ☐ RLE: ☐5 ☐4 ☐3 ☐2 ☐1 ☐0

☐ Left Hand: ☐5 ☐4 ☐3 ☐2 ☐1 ☐0 ☐ Right Hand: ☐5 ☐4 ☐3 ☐2 ☐1 ☐0

Comments

BALANCE/GAIT

SITTING ☐ No Deficit ☐ Altered Describe: _____

STANDING ☐ No Deficit ☐ Altered Describe: _____

GAIT ☐ Shuffling ☐ Unsteady ☐ Tremors

Gait Surfaces: *(Indicate highest level of function)*

4 - Navigates various surfaces without assistive device
3 - Navigates various surfaces with assistive device
2 - Navigates flat surfaces without assistive device
1 - Navigates flat surfaces with assistive device
0 - Unable to navigate flat surfaces with or without assistive device

BALANCE/GAIT

Berg Score: _____

Tinetti Score: _____

Other: _____

Gait Surface Score: _____

Gait Distance/Speed:

Distance: _____ ft per sec/min ☐ With assistive device ☐ Without assistive device

Speed for 1 meter: _____

Comments

JOINTS

☐ No Deficit ☐ Enlarged ☐ Warm/Red ☐ Stiff ☐ Painful

Comments

PROSTHETIC DEVICE/ADAPTIVE EQUIPMENT

☐ None
☐ Cast/Splint due to: _____
☐ Prosthesis due to: _____
☐ Adaptive Device due to: _____
☐ Cane due to: _____
☐ Walker due to: _____
☐ Other: _____

Comments

SENSORY EFFECTS ON THERAPY

☐ Vision ☐ Vertigo ☐ Medications ☐ Impaired Cognition ☐ Other: _____

Comments

TRANSFERS

KEY: 5 = Maximum Assist 4 = Moderate Assist 3 = Minimum Assist 2 = Standby Assist 1 = Independent AD = With Assistive Device W/O AD = Without Assistive Device

☐ Bed Mobility _____ ☐ AD ☐ W/O AD	☐ Chair _____ ☐ AD ☐ W/O AD	☐ _____ ☐ AD ☐ W/O AD
☐ In/Out of Bed _____ ☐ AD ☐ W/O AD	☐ Commode/Toilet _____ ☐ AD ☐ W/O AD	☐ _____ ☐ AD ☐ W/O AD
☐ Sit to Stand _____ ☐ AD ☐ W/O AD	☐ Tub/Shower _____ ☐ AD ☐ W/O AD	☐ _____ ☐ AD ☐ W/O AD

Performance Affected By: _____

Comments

ENDURANCE

☐ With assistive device ☐ Without assistive device

☐ 0 - Not troubled with breathlessness except with strenuous exercise
☐ 1 - Troubled by shortness of breath when hurrying on level surface or walking up a slight hill
☐ 2 - Walks slower than people of the same age on level surface because of breathlessness or has to stop for a breath when walking at own pace on level surface
☐ 3 - Usually too breathless to leave the house or breathless when dressing or undressing

Endurance Score: _____

Comments

EMOTIONAL STATUS/BEHAVIORS WHICH MAY IMPACT PLAN OF CARE

☐ None ☐ Identified as _____

Comments

HOME STRUCTURE/HOUSEHOLD BARRIERS THAT MAY IMPACT PLAN OF CARE

☐ None ☐ Identified as _____

Comments

NEUROLOGICAL ☐ WNL _____

SENSATION ☐ WNL _____

PALPATION ☐ Not Tested Location: _____

SKIN CONDITION ☐ WNL _____

EDEMA ☐ WNL _____

PHYSICAL THERAPY EVALUATION

PAIN

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

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

PAIN PROFILE

Primary Site: _____

Current pain management & effectiveness: _____

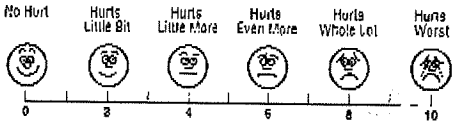
☐ Pain Management Teaching to patient/family *(document below)*

Patient's pain goal: _____

Progress toward pain goal: _____

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

WONG-BAKER FACES† PAIN RATING SCALE



† From Hockenberry MJ, Wilson D: Wong's essentials of pediatric nursing, ed. 8, St. Louis, 2009, Mosby. Used with permission. Copyright Mosby.

Comments

HOMEBOUND ☐ NO ☐ YES

If YES, give reason: _____

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

ANY ADDITIONAL PROBLEMS IDENTIFIED _____

PHYSICAL THERAPY ORDERS

Frequency/Duration of PT Visits: _____

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 _____	☐	☐	☐
☐ HOME CPM MACHINE _____	☐	☐	☐
☐ CAST CARE _____	☐	☐	☐
☐ PROSTHETIC DEVICE _____	☐	☐	☐
☐ ADAPTIVE DEVICE _____	☐	☐	☐
☐ WHEELCHAIR MEASUREMENT/FITTINGS _____	☐	☐	☐
☐ CIRCULATORY CHECKS AS APPLICABLE _____	☐	☐	☐
☐ BED MOBILITY _____	☐	☐	☐
☐ TRANSFER TECHNIQUES _____	☐	☐	☐
☐ ENDURANCE IMPROVEMENT/STRENGTH EXERCISES _____	☐	☐	☐

Additional Orders (specify): _____

GOALS/REHABILITATION POTENTIAL/DISCHARGE PLANS

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 within _____ period of time.
- ☐ The patient/caregiver will verbalize understanding of medications as evidenced by recall of action/dose/side effects within _____ period of time.
- ☐ 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's ROM/Mobility will improve as evidenced by _____ within _____ period of time.
- ☐ The patient's Muscle Strength will improve as evidenced by _____ within _____ period of time.
- ☐ The patient's Balance will improve as evidenced by _____ within _____ period of time.
- ☐ The patient's Gait will improve as evidenced by _____ within _____ period of time.
- ☐ The patient's Ambulation will improve as evidenced by _____ within _____ period of time.
- ☐ The patient's Endurance will improve as evidenced by _____ within _____ period of time.
- ☐ The patient's Pain will be controlled and managed at the patient's own comfort level as verbalized by the patient/caregiver 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.
- ☐ Other: _____
- ☐ Other: _____
- ☐ Rehabilitation potential: _____

SPECIFIC PHYSICAL THERAPY GOALS

Measurable Short Term: _____

Measurable Long Term: _____

Discharge Plans

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

Skilled Services provided this visit and Patient Response: _____

PATIENT NAME	Patient Signature (optional per agency policy):	
Physical Therapist's Signature & Date of Verbal SOC Where Applicable:	Time In ☐ AM ☐ PM	PHYSICIAN'S SIGNATURE / DATE (optional per agency policy)
	Time Out ☐ AM ☐ PM	

CHECK ONE: ☐ G0151-PT ☐ G0159-PT Maintenance