TITLE: PHYSICAL THERAPY EVALUATION FORM	DOC ID: F161.0
LOCATION: HOME HEALTH	

PATIENT DEMOGRAPHICS

Patient Name:_____Certification Period: _____

Address:_____City:_____State:_____

Phone:_____Physician:_____Agency:_____

HISTORY

Diagnosis:_____

Pertinent History:_____

Prior Level of Function:_____

Cognitive Status:_____

Homebound Reason: □ Needs assistance for all activities □ Residual Weakness □ Medical Restriction

□ Confusion, unable to go out of home alone □ Severe SOB, SOB upon exertion □ Unable to safely go out of home

□Dependent upon adaptive devices □ Requires assistance to ambulate □ Other:_____

ASSESSMENT

Vitals: Temp:_____ BP:_____ Pulse:_____ Resp:_____O2 Sat:_____(w/exertion)_____

Pain- Location:_____Intensity:_____(0-10 scale)

Precipitating Factors:_____Alleviating Factors:_____

Living Situation:_____Primary Caregiver:_____

Architectural Barriers:_____

Durable Medical Equipment:_____

Posture:_____

Balance: History of Falls □ Yes □ No Frequency of Falls:_____Most Recent:_____

Static Sitting:_____Dynamic Sitting:_____

Static Standing:_____Dynamic Standing:_____

Transfers:

Roll-Scoot in bed	□ I □ ModI □ Sup □ SBA □ CGA □ Min A □ Mod A □ Max A □ D	Comments:_____
Supine to Sit	□ I □ ModI □ Sup □ SBA □ CGA □ Min A □ Mod A □ Max A □ D	_____
Sit to Stand	□ I □ ModI □ Sup □ SBA □ CGA □ Min A □ Mod A □ Max A □ D	_____
Stand to Sit	□ I □ ModI □ Sup □ SBA □ CGA □ Min A □ Mod A □ Max A □ D	_____
On/Off Commode	□ I □ ModI □ Sup □ SBA □ CGA □ Min A □ Mod A □ Max A □ D	_____
In/Out of Car	□ I □ ModI □ Sup □ SBA □ CGA □ Min A □ Mod A □ Max A □ D	_____

Ambulation: SOB with ambulation: □ Yes □ No WB status:_____

Assistive Device:_____Distance:_____

Level Surfaces: □ I □ ModI □ Sup □ SBA □ CGA □ Min A □ Mod A □ Max A □ D

Uneven Suraces: □ I □ ModI □ Sup □ SBA □ CGA □ Min A □ Mod A □ Max A □ D

Up/Down Stairs: □ I □ ModI □ Sup □ SBA □ CGA □ Min A □ Mod A □ Max A □ D

Quality/Comments:_____

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Additional Comments:

STRENGHT/ROM

	Right	Left	Right	Left		Right	Left	Right	Left
Shoulder Flex.					**Hip** Flexion				
Extension					Extension				
Abduction					Abduction				
Int. Rotation					Int. Rotation				
Ext. Rotation					Ext. Rotation				
ElbowFlexion					**Knee** Flexion				
Extension					Extension				
Wrist Flexion					**Ankle** Dorsiflexion				
Extension					Plantarflexion				
Hand Grasp					Inversion/ Eversion				

OBJECTIVE MEASURES

□ Tinetti □TUG □_____Score:_____
Comment:_____

PLAN OF CARE

□ Evaluation □Home Exercise Program □ Patient Education □Gait Training □Therapeutic Exercise
□Muscle Reeducation □Coordination/Balance Training □Pain Management □Other_____

MEASURABLE THERAPY TREATMENT GOALS

Short Term:_____
_____
_____

Long Term:_____
_____
_____
_____
_____
_____
_____

Rehab Potential: □Excellent □Good □Fair □Poor □Limited Due To: _____

Discharge Plans: Patient to be discharged from physical therapy when: □Goals Met □ Maximum Fuctional Potential Met □ Physician's Orders Change □ Other_____
□ Plan of Care &Goals were discussed with and understood by patient/caregiver

Therapist Signature & Date:	Time In/Out:	Frequency:
Patient Name:	Patient Signature/Date:	
Physician Signature:		Date:

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