PHYSICAL THERAPY EVALUATION

OBJECTIVE DATA TESTS AND SCALES PRINTED ON REVERSE.

DATE OF SERVICE_____/_____/_____

HOMEBOUND REASON: ❑ Needs assistance for all activities ❑ Residual weakness
❑ Requires assistance to ambulate ❑ Confusion, unable to go out of home alone
❑ Unable to safely leave home unassisted ❑ Severe SOB, SOB upon exertion
❑ Dependent upon adaptive device(s) ❑ Medical restrictions
❑ Other (specify)_____

SOC DATE_____/_____/_____
(If Initial Evaluation, complete Physical Therapy Care Plan)

PERTINENT BACKGROUND INFORMATION

OTHER DISCIPLINES PROVIDING CARE: ❑ SN ❑ OT ❑ ST ❑ MSW ❑ Aide

MEDICAL HISTORY

❑ Hypertension ❑ Cancer
❑ Cardiac ❑ Infection
❑ Diabetes ❑ Immunosuppressed
❑ Respiratory ❑ Open wound
❑ Osteoporosis ❑ Falls with injury
❑ Fractures ❑ Falls without injury
❑ Other (specify)_____

REASON FOR EVALUATION (Diagnosis/Problem)

_____
_____
_____
_____
_____
_____

LIVING SITUATION

❑ Capable ❑ Able ❑ Willing caregiver available
❑ Limited caregiver support (ability/willingness)
❑ No caregiver available

HOME SAFETY BARRIERS:
❑ Clutter ❑ Throw rugs ❑ Bath bench/equipment ❑ Needs grab bar
❑ Needs railings ❑ Steps (number/condition) _____
❑ Other (specify)_____
_____

PRIOR LEVEL OF FUNCTION

ADLs:
❑ Independent ❑ Needed assistance ❑ Unable
Equipment used:_____

IN-HOME MOBILITY (gait or wheelchair/scooter):
❑ Independent ❑ Needed assistance ❑ Unable
Equipment used:_____

COMMUNITY MOBILITY (gait or wheelchair/scooter):
❑ Independent ❑ Needed assistance ❑ Unable
Equipment used:_____

BEHAVIOR/MENTAL STATUS

❑ Alert ❑ Oriented ❑ Cooperative ❑ Confused ❑ Memory deficits
❑ Impaired judgement ❑ Other (specify) _____
_____

VITAL SIGNS/CURRENT STATUS

Blood Pressure:_____
Temperature:_____
Pulse:_____
Respirations:_____
O_2 saturation _____% (when ordered): ❑ at rest ❑ with activity
Skin:_____
Edema:_____
Vision:_____
Sensation:_____
Communication:_____
Hearing:_____
Posture:_____
Endurance:_____

PAIN

INTENSITY: 0 1 2 3 4 5 6 7 8 9 10
LOCATION:_____
AGGRAVATING FACTORS:_____
_____
_____
RELIEVING FACTORS:_____
_____
_____
BEST PAIN GETS:_____ **WORST PAIN GETS:**_____
ACCEPTABLE LEVEL OF PAIN:_____
CURRENT LEVEL OF PAIN:_____
IMPACT ON THERAPY POC? ❑ **None** ❑ **(describe)**_____
_____
_____

PATIENT NAME – Last, First, Middle Initial	ID#

PHYSICAL THERAPY EVALUATION (Cont'd.)

MUSCLE STRENGTH/FUNCTIONAL ROM EVAL

	AREA	STRENGTH Right	STRENGTH Left	ACTION	ROM Right	ROM Left
UPPER EXTREM.	Shoulder			Flex/Extend		
				Abd./Add.		
				Int. Rot./Ext. Rot.		
	Elbow			Flex/Extend		
	Forearm			Sup./Pron.		
	Wrist			Flex/Extend		
	Fingers			Flex/Extend		
LOWER EXTREM.	Hip			Flex/Extend		
				Abd./Add.		
				Int. Rot./Ext. Rot.		
	Knee			Flex/Extend		
	Ankle			Plant./Dors.		
	Foot			Inver./Ever.		
SPINE	AREA	STRENGTH		ACTION	ROM	

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

FUNCTIONAL INDEPENDENCE/BALANCE EVAL

	TASKS	ASSIST SCORE	ASSISTIVE DEVICES/COMMENTS
BED MOBILITY	Roll/Turn		
	Sit/Supine		
	Scoot/Bridge		
TRANSFERS	Sit/Stand		
	Bed/Wheelchair		
	Toilet		
	Floor		
	Auto		
BALANCE	Static Sitting		
	Dynamic Sitting		
	Static Standing		
	Dynamic Standing		
W/C SKILLS	Propulsion		
	Pressure Reliefs		
	Foot Rests		
	Locks		

FUNCTIONAL INDEPENDENCE SCALE (bed mobility, transfers, balance, W/C skills)

GRADE	DESCRIPTION
5	Independent - physically able and independent.
4	Verbal cue (VC) only needed.
3	Stand-by assist (SBA) - 100% patient/client effort.
2	Minimum assist (Min A) - 75% patient/client effort.
1	Maximum assist (Max A) - 25% - 50% patient/client effort.
0	Totally dependent - total care/support.

GAIT

ASSISTANCE: ❑ Independent ❑ SBA ❑ Min. assist ❑ Mod. assist ❑ Max. assist ❑ Unable

SURFACES: ❑ Level ❑ Uneven ❑ Stairs (number/condition)_____ **DISTANCE/TIME:**_____

WEIGHT BEARING STATUS: ❑ FWB ❑ WBAT ❑ PWB ❑ TDWB ❑ NWB

ASSISTIVE DEVICE(S): ❑ Cane ❑ Quad Cane ❑ Crutches ❑ Hemi Walker ❑ Walker ❑ Wheeled Walker

❑ Other (specify)_____

QUALITY/DEVIATIONS/POSTURES:_____

SUMMARY

Instruction provided: ❑ Safety ❑ Exercise ❑ Other (describe)_____

Equipment needed (describe)_____

❑ PT Evaluation only. No further indications for PT services.

❑ Orders for PT evaluation only. Needs additional PT services. See PT Care Plan for recommendations.

❑ Need to obtain orders.

❑ Orders for PT services with specific treatments, frequency and duration. See PT Care Plan/485.

DISCHARGE DISCUSSED WITH: ❑ Patient/Family

❑ Care Manager ❑ Physician ❑ Other (specify)_____

CARE COORDINATION: ❑ Physician ❑ SN ❑ PT ❑ OT ❑ ST ❑ MSW

❑ Aide ❑ Other (specify)_____

APPROXIMATE NEXT VISIT DATE_____/_____/_____

PLAN FOR NEXT VISIT_____

_____

_____

PATIENT SIGNATURE (if applicable)_____

THERAPIST'S SIGNATURE/TITLE_____

DATE_____/_____/_____ **TIME IN**_____ **TIME OUT**_____