PHYSICAL THERAPY VISIT NOTE

Patient Name: _____ Date: __/__ /____ Time In: _____ am/pm Out: ____ am/pm

Agency Name: _____

Patient Complaint/problems: _____

_____

Is this patient still home bound: Yes No Reason: _____

Clinical Findings:

Vital Signs: **Before** Pulse___/min BP___/___ RR___/min **After** Pulse___/min BP___/___ RR___/min

Pain: Severity Level: 0 1 2 3 4 5 6 7 8 9 10 Location:_____

ROM: _____ **Muscle strength: Improved/Decreased**: _____

WB Status: _____

Current Functional Status

Functional Assessment	Ind	Sup	CG	Min	Mod	Max	Dep	NA	Comments and Training done
Bed mobility									
Supine to sit									
Transfer i/o of bed									
Bed to chair									
Sit to stand									
Toilet/commode									
Shower/tub transfer									
Orthosis/ prosthesis									

Ambulation	Ind	Sup	VC	CG	Min	Mod	Max	A Device	Distance
Indoors									
Outdoors									
# of stairs									

Gait Deviations and Training: _____

_____

Progressive Balance and Coordination Training:

Sitting - Static: ___ dynamic___ **Standing**: Static:___ dynamic___ Leaning forward___ Reaching over___ single leg stance___ Side step __ Backward walk__ Alternating Motion__ Reciprocal motion__ Sequence activities__ Movement activities

Other_____

Progressive Therapeutic Exercise: ___PROM ___ AAROM___ Resistive Strengthening ___Non Resistive Strengthening ___ Stretching exercises ___Joint mobilization

Patient Name_____ Date__ /__ /___

Exercise Intervention	Sets/Reps/Resistance

Evaluation of Intervention

Patient Response: _____Functional ability improved towards goals since last visit_____ Functional ability unchanged since last visit Patient requires further treatment and teaching___ Other: _____
Comments: _____

Caregiver response to teaching: __Has adequate knowledge to assist patient in functional activities safely__ Requires further teaching and supervision__ Follows suggested prescribed plan__ No caregiver Other _____
Comments: _____

Establish and Upgrade Home Exercise Program

New HEP: ____Written copy to patients _____patient taught to perform exercise____ Caregiver/HHA instructed to assist

Revised HEP: ____modified activities____ Modified resistance ____Modified Reps/Sets____ Modified frequency/duration

Patient Response: __ Patient independent with HEP __Requires further supervision/teaching __ Caregiver/HHA demonstrates ability to assist with HEP safely __ Requires further teaching Other:_____

Functional Measures:

Patient still at risks for falls ___Yes __No Time Up and Go test score __sec Continue falls prevention __Yes_-No

Other: _____

Comments: _____

Continuation of therapy: Continue visits, Frequency ___ x wk ___Discharge visit ___ Dc plan discussed with patient

Reason for continued need for skilled therapy_____

Communication of care: RN__ OT__ ST__ CM__ MD__ HHA__ Family___ Other_____

Re: _____

Therapist Name: _____ Signature/Title: _____

Revisit date __/__/___ Patient Signature: _____