PHYSICAL THERAPY ASSESSMENT

AGENCY: _____

☐ Initial Eval ☐ Reassessment ☐ Reassessment 13th visit ☐ Reassessment 19th visit ☐ 30th day Reassessment ☐ DC Visit

Patient Name: _____ Date:_____ PT Visit #____ Combined visit #____
MR#_____ DOB: _____ Physician: _____ Cert. period _____ to _____

PATIENT HISTORY

MEDICAL DIAGNOSIS:_____ THERAPY DIAGNOSIS: _____
Onset: _____ Recent Hospital admit: ☐ No ☐ Yes _____ Prior Therapy: _____
PLOF: _____ Precautions: _____
☐ Cancer ☐ Choking/ Aspiration ☐ Congestive Heart Failure ☐ COPD ☐ CVA ☐Diabetes ☐ Fractures
☐ History of falls ☐ Hypertension ☐ Infection ☐ Myocardial Infarction ☐ Osteoporosis ☐Psychiatric History
☐Recent Weight Loss/Gain ☐ History of Patient Abuse/ Neglect ☐ Other: _____
☐ No changes since last assessment Comments: _____
MENTAL AND CONGNITIVE STATUS: _____

PAIN: Intensity: ___/10 Location: _____ Type: ☐ Acute ☐ Chronic ☐ Constant ☐ Intermittent
Relieving factors: _____
PAIN: Intensity: ___/10 Location: _____ Type: ☐ Acute ☐ Chronic ☐ Constant ☐ Intermittent
Relieving factors: _____
VITALS: Prior to activity: BP: _____ HR: _____ RR: _____ O2: _____
VITALS: Post activity: BP: _____ HR: _____ RR: _____ O2: _____
☐ Vitals recorded in home folder ☐ CSM called if abnormal Comments: _____

SUBJECTIVE

HOME ENVIRONMENT

Mobility Pathways:
☐ Adequate ☐ Obstructed
☐ Cluttered ☐ Other: _____
☐ Throw Rugs

Steps in Home:
☐ No ☐Yes, #_____ ☐ Railing ☐ Rt. ☐ Lt.

Support Assistance:
☐ Caregiver able to assist in care ☐ Caregiver with limited ability to assist in care ☐ No Caregiver available ☐ Patient needs assistance of Caregiver Safety Recommendation:

EQUIPMENT IN HOME

☐ No equipment ☐ Cane ☐ Commode ☐ Sliding Board ☐ Bath Safety Bars ☐ Tub/ Shower Seat
☐ Hoyer Lift ☐ Wheelchair ☐ Walker ☐ Hospital Bed ☐ Raised Toilet Seat ☐ Transfer/Gait Belt
☐ Oxygen ☐ Other: _____ Equipment needed: _____

STRENGTH, ROM, NEUROLOGICAL ASSESSMENT

	STRENGTH		ROM	
	L	R	L	R
Cervical				
Shoulder Flexion				
Abduction				
Int. Rot.				
Ext. Rot.				
Elbow Flexion				
Extension				
Supination				
Wrist Flexion				
Extension				
Finger Flexion				
Extension				
Hip Flexion				
Extension				
Abduction				
Int. Rot.				
Ext. Rot.				
Knee Flexion				
Extension				
Ankle Plantar				
Dorsiflexion				

FUNCTIONAL ACTIVITY ASSESSMENT

Task	Assist Level	Comments/ Assistive Device Needed
Bed Mobility		
Rolling Left		
Rolling Right		
Scooting		
Bridging		
Supine to Sit		
Sit to Supine		
Transfers		
Bed to Chair		
Sit to Stand		
Toilet		
Tub/ Shower		
Low Surfaces		
W/C Mobility		
Propulsion		
Turns		
Incline		
Repositioning		

Balance: Sitting: Static _____
Dynamic _____

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