Healing Hands Home Health Care

Physical Therapy Evaluation

Name:____ Date: __________

Time in:________ Time out:_________

Address:____

Phone number:________________________ Physician:_________________________

Diagnosis:____

Certification Period: _____________ to _______________

Subjective History:____

Prior Treatment References:

		Strength		ROM		Independent Curing Assistance needed Unable to perform				
		R	**L**	**R**	**L**		**I**	**C**	**A**	**U**
Shoulder	Flex					Dressing				
	Abd					Bathing/ Tub				
	IR					Bathing/shower				
	ER					Eating				
Elbow	Flex					Cooking				
	Pron					Ambulation				
	Ext					Toileting				
	Sup					Laundry				
Wrist	Flex					Transfers				
	Ext					W/V Propulsion				
Finger	Flex					Rolling				
	Ext					Sitting				
Grip						Stairs				
Hip	Flex					Personal Hygiene				
	Ext					Using Telephone				
	Abd					Housekeeping				
	IR									
	ER									
Knee	Flex									
	Ext									
Ankle	DF									
	PF									
	IN									
	EV									

Gait Eval:		
Mental Status/ Motivation:		
Circulation/ Edema:		
Assistive Devices:		
Posture:		
Muscle Tone:		
Sensation/ Proprioception:		
Balance: Sitting:	Sit to Stand:	Standing:
Ambulating:	Endurance:	

Assessment:

Prognosis:	Progressive	Good	Fair	**Has diagnosis**	Patient	Yes	No
	Guarded	Poor	Terminal	**Prognosis been told to:**	Family	Yes	No

Goals:

☐Patient/ Caregiver to be independent with home exercise program within ________________
☐Patient to ambulate ______ distance using ____________ assistive device with _________ assistance within ________________
☐Patient to require ___________ assistance for transfers/ bed mobility within ___________________
☐Patient to ambulate on stars using ______________ assistive device with ____________assistance within ____________.
☐Increased ROM of _________ joint to __________ within ______________.
☐Sitting/ Standing balance to improve to fair or good within ___________________.
☐Decreased intensity/ frequency of pain within __________________.l
☐ Increase strength/ endurance of ____________ extremities to/by ___________ within ____________.
☐Other: ____

Plan of Treatment:

☐BO. Physical Therapy

☐Evaluation Only

Frequency	Duration

☐B1 Evaluation
☐B2 Therapeutic Exercise
☐B3 Establish or Upgrade Home Program
☐B4 Cardiopulmonary Physical Therapy
☐B5 Electrotherapy
☐B6 Fabrication Temporary Devices
☐B7 Management and Evaluation of a Care Plan
☐B8 Resistive Exercise
☐B9 Transfer Training
☐B10 Gait Training
☐B11 Ultrasound
☐B12 Prosthetic Training
☐B 13 Muscle Reeducation
☐B14 Active Exercise
☐B15 Stretching Exercise
☐B16 Other ____

Treatment: ____
____
____
____

Therapist Signature:___________________________ Client Signature: __________________________

Doctor Signature: _____________________________ Date: _______________________