HEALING HANDS HOME HEALTH CARE

Physical Therapy Note

Date: _____

Client Name: Client ID: Time In: Time Out:

Subjective:

Objective: **LE's**

Quad Sets
Ham sets
Ankle pumps
SAQ
Heel slides
Supine hip flexion
LAQ's
Seated hip flexion
Seated hip abd.
Seated heel & toe raises
SLR
Glute Sets
Others:

UE's

Elbow fix/ext.
Shldr. Fix/ext.
Shldr. abd./add.
Horiz. Shldr. Abd./add.
Shldr. Presses
Shldr. Shrugs
Scapular retraction
Cervical stretches

Others:

Balance and Strengthening

Standing hip ext.
Standing hip abd.
Standing hip fix.
Wall squats
Standing heel raises
Standing hs curls
Side stepping
Retro-walking
Braiding
Wt. shifting
Others

Transfers:

Sit<>stand
Supine<>sit
Floor
Other:

Bed mobility
Shower/tub
Toilet

ROM:

Ambulation:

WB status	R	L	Asst. Device
PWB			None
NWB			Cane
WBAT			Quad Cane
TTWB			Walker
FWB			Wheelchair
			Crutches

Surfaces	Ind.	SBA/CGA	Min	Mod	Max	Distance
Even						
Stairs						
Uneven						

Balance	Good	Fair	Poor
Sitting			
Sit>Stand			
Standing			
Ambul.			

Gait Training:

Other:

Reasons Home Bound: ☐ Unable to Manage Steps ☐ Limited Endurance ☐ Required Assistance ☐ Other

Additional Comments:

Care Coordination: ☐ Aide ☐ CPTA ☐ RN ☐ OT ☐ DR ☐ Patient ☐ Caregiver ☐ Other

Outcome:

Change in Frequency: Patient/Family informed

CPTA Supervisory Visit

Therapist Signature: _____ **Client Signature:** _____