etairos HEALTH Your Partner at Home

PHYSICAL THERAPY ROUTINE VISIT

Client Name: _____	Employee Printed Name: _____
Client Signature: _____	Employee Signature: _____
	Date: _____ Time In: _____ Time Out: _____

Functional Limitations / Activities Permitted: _____

DME: _____

Vital Signs: BP: _____ Pulse: _____ Resp. Rate: _____

Mental Status: ☐ Alert ☐ Oriented ☐ Cooperative ☐ Confused ☐ Memory Deficits ☐ Impaired Judgement

☐ Other: _____

Home Safety Barriers: ☐ Clutter ☐ Throw Rugs ☐ Needs Grab Bars ☐ Needs Railings

☐ Other: _____

Skilled Treatment:

☐ Therapeutic Exercise/Technique: ☐ PROM ☐ AROM ☐ AAROM _____

☐ Resistive Exercise _____

☐ Relaxation Exercises ☐ Energy Conservation _____

☐ Developmental / Facilitation Techniques _____

☐ Balance and Coordination Training _____

☐ Cognitive Retraining Strategies _____

☐ Breathing Retraining _____

☐ Posture Retraining / Body Mechanics _____

☐ Functional Mobility Training _____

☐ Bed Mobility Training _____

☐ Transfer Training _____

☐ Wheelchair Training _____

☐ Gait Training ☐ Stairs ☐ Uneven Surface

Distance: _____ Cueing: _____

Assist: _____ Pattern: _____

Instructions / Supervision:

Instructions given to: ☐ Client ☐ Family / Caregiver _____ ☐ Other _____

☐ HHA _____ HHA Response: _____

☐ Home Exercise / Activity Program ☐ Home Use of DME _____ ☐ Emergency Management

☐ Home Safety Measures _____ ☐ Posture / Body Mechanics ☐ Positioning

☐ Energy Conservation ☐ Disease Process ☐ Mobility Techniques ☐ Ambulation Techniques

☐ Use of Assistive Devices / Orthotics

☐ Instruct / Reinforce Orthopedic Instructions _____

Client / Family Response _____

Pain Evaluation:

☐ No Current Pain *(Go to Homebound Status)*
☐ Pain is well controlled with current POC ☐ Client needs ongoing education and reinforcement of pain regimen
☐ Family / PCG needs ongoing education and reinforcement of pain regimen ☐ Refuses additional pain treatment
☐ Changes necessary / Other: _____
Pain: Location(s): _____
Frequency / Pattern: _____ Exacerbated by: _____
Type: _____ Character: _____ Current Rating for Pain (1-10 Scale): _____
Treatment Relieved by: ☐ Rest ☐ Heat ☐ Ice ☐ Pain Meds: _____
☐ Exercise ☐ Stretching ☐ Other: _____
Barriers to Pain Control: _____
Paint Management Education: ☐ Educational Materials Given ☐ Instructions Given / Response: _____
_____
Instructions Given to: ☐ Patient ☐ Family / Caregiver: _____ ☐ Other: _____
Homebound Status: *At least weekly, add a comment to explain in detail patient's homebound status*
☐ Homebound due to taxing effort to leave home
☐ Homebound due to requires assist of another person and/or device to leave home
☐ Homebound due to leaves home for medical appointments and/or for religious services only
☐ Homebound due to absences from home for social reasons are infrequent and require considerable effort
☐ Homebound due to unable to leave home due to psychological limitations
☐ Homebound due to: _____
☐ Client / Family Comment: _____
_____
☐ **Case Conference PTA** *(include review POC, appropriate modifications to treatment regime):* _____
_____
Narrative: *Include assessment, progress towards goals, communication with other disciplines and plan for next treatment*

Plan for next treatment: _____