Physical Therapy Evaluation

☐ Initial  ☐ Re-evaluation

Primary Dx (PT related) __________________________ Date of Onset / Exacerbation __________________________
Surgical Procedure __________________________ Date __________________________
Other Dx with Dates __________________________

Homebound Status:  ☑ Needs assistance w/all activities  ☑ Residual weakness  ☑ SOB w/exertion  ☑ Medical restrictions
☐ N/A  ☑ Requires assistance to ambulate  ☑ Confusion/Cognitive limitations  ☑ Other: __________________________
Comments: __________________________

Precautions:  ☑ N/A  ☑ Unstable VS  ☑ THR (R/L)  ☑ Wt. Bearing __________________________  ☑ Falls  ☑ Cardiac  ☑ Pacemaker
☐ Secretions/drainage  ☑ Other __________________________

Subjective

Hx: __________________________

Prior level of function __________________________
Patient goals __________________________

Objective: (Abbreviations for assistance required: I = independent, VC = verbal cues, CGA = contact guard, SBA = standby, Min., Mod., Max.)

☐ Observations (v.s., posture, edema, wounds, etc.) __________________________

Range of Motion

Upper extremity, right ☑ WNL  ☑ WFL  ☑ Impaired __________________________
Upper extremity, left ☑ WNL  ☑ WFL  ☑ Impaired __________________________
Lower extremity, right ☑ WNL  ☑ WFL  ☑ Impaired __________________________
Lower extremity, left ☑ WNL  ☑ WFL  ☑ Impaired __________________________

Comments: __________________________

Strength

Upper extremity, right ☑ WNL  ☑ WFL  ☑ Impaired __________________________
Upper extremity, left ☑ WNL  ☑ WFL  ☑ Impaired __________________________
Lower extremity, right ☑ WNL  ☑ WFL  ☑ Impaired __________________________
Lower extremity, left ☑ WNL  ☑ WFL  ☑ Impaired __________________________

Comments: __________________________

Neurologic

Sensation: light touch
Upper extremity, right ☑ Intact ☑ Impaired ☑ Absent __________________________
Upper extremity, left ☑ Intact ☑ Impaired ☑ Absent __________________________
Lower extremity, right ☑ Intact ☑ Impaired ☑ Absent __________________________
Lower extremity, left ☑ Intact ☑ Impaired ☑ Absent __________________________

Sensation: sharp/dull
Upper extremity, right ☑ Intact ☑ Impaired ☑ Absent __________________________
Upper extremity, left ☑ Intact ☑ Impaired ☑ Absent __________________________
Lower extremity, right ☑ Intact ☑ Impaired ☑ Absent __________________________
Lower extremity, left ☑ Intact ☑ Impaired ☑ Absent __________________________

Proprioception
Upper extremity, right ☑ Intact ☑ Impaired ☑ Absent __________________________
Upper extremity, left ☑ Intact ☑ Impaired ☑ Absent __________________________
Lower extremity, right ☑ Intact ☑ Impaired ☑ Absent __________________________
Lower extremity, left ☑ Intact ☑ Impaired ☑ Absent __________________________

☐ Other/comments (DTRs, pathological reflexes, etc.) __________________________

☐ Abnormal tone __________________________

Patient Name: __________________________
Patient ID No.: __________________________
Date: __________________________

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Pain Scale:

(With 10 being worst possible)

Before: ____________________

During: ____________________

After: ____________________

No Hurt  
Little Bit  
Little More  
Even More  
Whole Lot  
Worst

☐ Intermittent  ☐ Constant  ☐ Sharp  ☐ Dull  ↑ W/  ↓ W/__________________________

Physical Therapy Evaluation

Mobility/Transfers

☐ Rolling
☐ Scooting
☐ Supine ↔ Sit
☐ Sit ↔ Stand
☐ Level surface transfer
☐ Unlevel surface transfer
☐ Commode/Bath transfer
☐ Car transfer
☐ Floor ↔ Stand
☐ Wheelchair mobility

I: VC: CGA: SBA: Min: Mod: Max: Dependent: Comments:

Balance (grade 1 - 7, 1 = requires max support, 4 = independent without support but holds against no force, 7 = against max force/normal)

☐ Standing w/device  Static: Dynamic: ☐ Balance reactions: ☐ Present ☐ Impaired ☐ Absent
☐ Standing w/o device  Static: Dynamic: ☐ Functional reach:
☐ Sitting: Static: Dynamic:

☐ Other/comments:

Coordination  ☐ WNL  ☐ Impaired__________

Gait

Assistive device:  ☐ Noe  ☐ Straight cane  ☐ Small base quad cane  ☐ Large base quad cane  ☐ Hemi-walker
☐ Axillary crutches  ☐ Forearm crutches  ☐ Walker  ☐ Rolling walker  ☐ Platform walker (R/L)

Wt. bearing limitations: __________________________ (R/L)  ☐ Patient compliant  ☐ Patient non-compliant

Even surface  ☐ VC  ☐ CGA  ☐ SBA  ☐ Min: Mod: Max: Dependent:

Uneven surface  ☐ VC  ☐ CGA  ☐ SBA

Incline/decline: ☐ VC  ☐ CGA  ☐ SBA

↑ ↓ Steps

Description of gait deviations:

Supplies

<table>
<thead>
<tr>
<th>Quantity</th>
<th>Description</th>
<th>Quantity</th>
<th>Description</th>
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</thead>
</table>

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Patient/Caregiver's Agreement to Plan

Your physician has ordered the services listed below be provided to you on an intermittent basis. If you have a preference, indicate the day and time you would prefer our service. Our staff will try to honor your request if possible. You will be notified in advance of any schedule changes.

<table>
<thead>
<tr>
<th>Physical Therapy</th>
<th>Frequency/Duration</th>
<th>Preference (Day/Time)</th>
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</thead>
</table>


Patient/Caregiver's Signature:

---

Physical Therapy Evaluation

I, __________________________________________, certify that the employee arrived at _______ am/pm, left at _______ am/pm, and provided satisfactory care.

(Patient/Caregiver Signature)

Exclusion Time: ____________________________ Reason for Exclusion: ____________________________

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I certify that these notes: (1) are true and do not omit any material fact(s) that would mislead about the patient's status; and (2) were not prepared or changed by any supervisor, nor did any supervisor require me to change these notes, in any manner that is untrue, inaccurate or misleading. Signature/Title: __________________________________________ Date: ____________________________

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**Complete this information only if the patient is not admitted**

**NON-ADMIT INFORMATION**

**Reason for Non-Admission**

- [ ] Appropriate level services not approved by payor
- [ ] Another company already providing requested services
- [ ] Services ordered not medically necessary/indicated
- [ ] Environment unsafe/inappropriate of carrying out plan of care
- [ ] Hot Homebound
- [ ] Denial of requested services/equipment by payor
- [ ] Patient and/or caregiver request
- [ ] Physician request
- [ ] Unable to provide services requested by patient and/or caregiver

Therapist's Name __________________________________________ Date: ____________________________

**Non-Admit Notifications:**

- [ ] Doctor Notified
- [ ] Referral Source Notified
- [ ] Notice of Non-Coverage
- [ ] Non-Admit Information Filed

<table>
<thead>
<tr>
<th>Non-Admit Notifications</th>
<th>DATE</th>
<th>SIGNATURE</th>
<th>COMMENTS</th>
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<tbody>
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Patient Name: ____________________________ Patient ID No.: ____________________________ Date: ____________________________