

DOCUMENTATION TEMPLATE FOR PHYSICAL THERAPIST
PATIENT/CLIENT MANAGEMENT
Outpatient Form 1, Page 1

Today's Date: _____
Patient ID#: _____

1 Name:

a Last _____
b First _____ c MI _____ d Jr/Sr _____

2 Street Address:

City _____ State _____ Zip _____

3 Date of Birth: Month Day Year
□□ □□ □□□□

4 Sex: a Male b Female

5 Are you: a Right-handed b Left-handed

6 Type of Insurance: a Insurer _____
b Workers' Comp c Medicare d Self-pay e Other

7 Race:

- a American Indian or Alaska Native
- b Asian
- c Black or African American
- d Hispanic or Latino
- e Native Hawaiian or Other Pacific Islander
- f White

8 Ethnicity:

- a Hispanic or Latino
- b Not Hispanic or Latino

9 Language:

- a English understood
- b Interpreter needed
- c Language you speak most often: _____

10 Education:

- a Highest grade completed (Circle one): 1 2 3 4 5 6 7 8 9 10 11 12
- b Some college / technical school
- c College graduate
- d Graduate school / advanced degree

SOCIAL HISTORY

11 Cultural/Religious: Any customs or religious beliefs or wishes that might affect care?

12 With whom do you live:

- a Alone
- b Spouse only
- c Spouse and other(s)
- d Child (not spouse)
- e Other relative(s) (not spouse or children)
- f Group setting
- g Personal care attendant
- h Other: _____

13 Have you completed an advance directive? a Yes b No

14 Who referred you to the physical therapist:

15 Employment/Work (Job/School/Play)

- a Working full-time outside of home
- b Working part-time outside of home
- c Working full-time from home
- d Working part-time from home
- e Homemaker
- f Student
- g Retired
- h Unemployed
- i Occupation: _____

LIVING ENVIRONMENT

16 Does your home have:

- a Stairs, no railing
- b Stairs, railing
- c Ramps
- d Elevator
- e Uneven terrain
- f Assistive devices (eg, bathroom): _____
- g Any obstacles: _____

17 Do you use:

- a Cane
- b Walker or rollator
- c Manual wheelchair
- d Motorized wheelchair
- e Glasses, hearing aids
- f Other: _____

18 Where do you live:

- a Private home
- b Private apartment
- c Rented room
- d Board and care / assisted living / group home
- e Homeless (with or without shelter)
- f Long-term care facility (nursing home)
- g Hospice
- h Other: _____

19 GENERAL HEALTH STATUS

- a Please rate your health:
(1) Excellent (2) Good (3) Fair (4) Poor
- b Have you had any major life changes during past year? (eg, new baby, job change, death of a family member) (1) Yes (2) No

20 SOCIAL/HEALTH HABITS

- a Smoking
 - (1) Currently smoke tobacco? (a) Yes 1. Cigarettes: # of packs per day ____
 - 2. Cigars/Pipes: # per day ____
 - (b) No
- (2) Smoked in past? (a) Yes Year quit: □□□□ (b) No
- b Alcohol
 - (1) How many days per week do you drink beer, wine, or other alcoholic beverages, on average? ____
 - (2) If one beer, one glass of wine, or one cocktail equals one drink, how many drinks do you have, on an average day? ____

c Exercise

- Do you exercise beyond normal daily activities and chores?
 - (a) Yes Describe the exercise: _____
 - 1. On average, how many days per week do you exercise or do physical activity? _____
 - 2. For how many minutes, on an average day? _____
 - (b) No

21 FAMILY HISTORY (Indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/grandfather, and age of onset if known)

- a Heart disease: _____
- b Hypertension: _____
- c Stroke: _____
- d Diabetes: _____
- e Cancer: _____
- f Psychological: _____
- g Arthritis: _____
- h Osteoporosis: _____
- i Other: _____

22 MEDICAL/SURGICAL HISTORY

a Please check if you have ever had:

- | | |
|--|---|
| (1) <input type="checkbox"/> Arthritis | (13) <input type="checkbox"/> Multiple sclerosis |
| (2) <input type="checkbox"/> Broken bones/
fractures | (14) <input type="checkbox"/> Muscular dystrophy |
| (3) <input type="checkbox"/> Osteoporosis | (15) <input type="checkbox"/> Parkinson disease |
| (4) <input type="checkbox"/> Blood disorders | (16) <input type="checkbox"/> Seizures/epilepsy |
| (5) <input type="checkbox"/> Circulation/vascular
problems | (17) <input type="checkbox"/> Allergies |
| (6) <input type="checkbox"/> Heart problems | (18) <input type="checkbox"/> Developmental or growth
problems |
| (7) <input type="checkbox"/> High blood
pressure | (19) <input type="checkbox"/> Thyroid problems |
| (8) <input type="checkbox"/> Lung problems | (20) <input type="checkbox"/> Cancer |
| (9) <input type="checkbox"/> Stroke | (21) <input type="checkbox"/> Infectious disease
(eg, tuberculosis, hepatitis) |
| (10) <input type="checkbox"/> Diabetes/
high blood sugar | (22) <input type="checkbox"/> Kidney problems |
| (11) <input type="checkbox"/> Low blood sugar/
hypoglycemia | (23) <input type="checkbox"/> Repeated infections |
| (12) <input type="checkbox"/> Head injury | (24) <input type="checkbox"/> Ulcers/stomach problems |
| | (25) <input type="checkbox"/> Skin diseases |
| | (26) <input type="checkbox"/> Depression |
| | (27) <input type="checkbox"/> Other: _____ |

b Within the past year, have you had any of the following symptoms? (Check all that apply)

- | | |
|---|---|
| (1) <input type="checkbox"/> Chest pain | (13) <input type="checkbox"/> Difficulty sleeping |
| (2) <input type="checkbox"/> Heart palpitations | (14) <input type="checkbox"/> Loss of appetite |
| (3) <input type="checkbox"/> Cough | (15) <input type="checkbox"/> Nausea/vomiting |
| (4) <input type="checkbox"/> Hoarseness | (16) <input type="checkbox"/> Difficulty swallowing |
| (5) <input type="checkbox"/> Shortness of breath | (17) <input type="checkbox"/> Bowel problems |
| (6) <input type="checkbox"/> Dizziness or blackouts | (18) <input type="checkbox"/> Weight loss/gain |
| (7) <input type="checkbox"/> Coordination problems | (19) <input type="checkbox"/> Urinary problems |
| (8) <input type="checkbox"/> Weakness in arms or legs | (20) <input type="checkbox"/> Fever/chills/sweats |
| (9) <input type="checkbox"/> Loss of balance | (21) <input type="checkbox"/> Headaches |
| (10) <input type="checkbox"/> Difficulty walking | (22) <input type="checkbox"/> Hearing problems |
| (11) <input type="checkbox"/> Joint pain or swelling | (23) <input type="checkbox"/> Vision problems |
| (12) <input type="checkbox"/> Pain at night | (24) <input type="checkbox"/> Other: _____ |

c Have you ever had surgery? (1) Yes (2) No
 If yes, please describe, and include dates:

	Month	Year
_____	□□	□□□□
_____	□□	□□□□
_____	□□	□□□□

For men only: d Have you been diagnosed with prostate disease?
 (1) Yes (2) No

For women only:

Have you been diagnosed with:

- | | |
|--|--|
| e Pelvic inflammatory
disease? | h Complicated pregnancies or
deliveries? |
| (1) <input type="checkbox"/> Yes (2) <input type="checkbox"/> No | (1) <input type="checkbox"/> Yes (2) <input type="checkbox"/> No |
| f Endometriosis? | i Pregnant, or think you might
be pregnant? |
| (1) <input type="checkbox"/> Yes (2) <input type="checkbox"/> No | (1) <input type="checkbox"/> Yes (2) <input type="checkbox"/> No |
| g Trouble with your period? | j Other gynecological or obstet-
rical difficulties? |
| (1) <input type="checkbox"/> Yes (2) <input type="checkbox"/> No | (1) <input type="checkbox"/> Yes (2) <input type="checkbox"/> No |
- If yes, please describe: _____

23 CURRENT CONDITION(S)/CHIEF COMPLAINT(S)

a Describe the problem(s) for which you seek physical therapy:

b When did the problem(s) begin (date)?

c What happened? _____

d Have you ever had the problem(s) before?

- (1) Yes
 (a) What did you do for the problem(s)? _____
- (b) Did the problem(s) get better?
 1. Yes 2. No
- (c) About how long did the problem(s) last? _____
- (2) No

23 Current Condition(s)/Chief Complaint(s) (continued)

e How are you taking care of the problem(s) now? _____

f What makes the problem(s) better? _____

g What makes the problem(s) worse? _____

h What are your goals for physical therapy? _____

i Are you seeing anyone else for the problem(s)? (Check all that apply)

- | | |
|--|--|
| (1) <input type="checkbox"/> Acupuncturist | (10) <input type="checkbox"/> Occupational therapist |
| (2) <input type="checkbox"/> Cardiologist | (11) <input type="checkbox"/> Orthopedist |
| (3) <input type="checkbox"/> Chiropractor | (12) <input type="checkbox"/> Osteopath |
| (4) <input type="checkbox"/> Dentist | (13) <input type="checkbox"/> Pediatrician |
| (5) <input type="checkbox"/> Family practitioner | (14) <input type="checkbox"/> Podiatrist |
| (6) <input type="checkbox"/> Internist | (15) <input type="checkbox"/> Primary care physician |
| (7) <input type="checkbox"/> Massage therapist | (16) <input type="checkbox"/> Rheumatologist |
| (8) <input type="checkbox"/> Neurologist | Other: _____ |
| (9) <input type="checkbox"/> Obstetrician/gynecologist | |

24 FUNCTIONAL STATUS/ACTIVITY LEVEL (Check all that apply):

a Difficulty with locomotion/movement:

- (1) bed mobility
- (2) transfers (such as moving from bed to chair, from
bed to commode)
- (3) gait (walking)
- (a) on level (c) on ramps
- (b) on stairs (d) on uneven terrain

b Difficulty with self-care (such as bathing, dressing, eating,
toileting)

c Difficulty with home management (such as household
chores, shopping, driving/transportation, care of dependents)

d Difficulty with community and work activities/integration

(1) work/school

(2) recreation or play activity

25 MEDICATIONS

a Do you take any prescription medications? (1) Yes (2) No
 If yes, please list: _____

b Do you take any nonprescription medications?
 (Check all that apply)

- | | |
|---|---|
| (1) <input type="checkbox"/> Advil/Aleve | (6) <input type="checkbox"/> Decongestants |
| (2) <input type="checkbox"/> Antacids | (7) <input type="checkbox"/> Herbal supplements |
| (3) <input type="checkbox"/> Ibuprofen/
Naproxen | (8) <input type="checkbox"/> Tylenol |
| (4) <input type="checkbox"/> Antihistamines | (9) <input type="checkbox"/> Other: _____ |
| (5) <input type="checkbox"/> Aspirin | |

c Have you taken any medications previously for the
condition for which you are seeing the physical therapist?
 (1) Yes (2) No If yes, please list: _____

26 OTHER CLINICAL TESTS—Within the past year, have you had any of
the following tests? (Check all that apply)

- | | |
|---|---|
| a <input type="checkbox"/> Angiogram | m <input type="checkbox"/> Mammogram |
| b <input type="checkbox"/> Arthroscopy | n <input type="checkbox"/> MRI |
| c <input type="checkbox"/> Biopsy | o <input type="checkbox"/> Myelogram |
| d <input type="checkbox"/> Blood tests | p <input type="checkbox"/> NCV (nerve conduction velocity) |
| e <input type="checkbox"/> Bone scan | q <input type="checkbox"/> Pap smear |
| f <input type="checkbox"/> Bronchoscopy | r <input type="checkbox"/> Pulmonary function test |
| g <input type="checkbox"/> CT scan | s <input type="checkbox"/> Spinal tap |
| h <input type="checkbox"/> Doppler ultrasound | t <input type="checkbox"/> Stool tests |
| i <input type="checkbox"/> Echocardiogram | u <input type="checkbox"/> Stress test (eg, treadmill, bicycle) |
| j <input type="checkbox"/> EEG (electroencephalogram) | v <input type="checkbox"/> Urine tests |
| k <input type="checkbox"/> EKG (electrocardiogram) | x <input type="checkbox"/> X-rays |
| l <input type="checkbox"/> EMG (electromyogram) | y <input type="checkbox"/> Other: _____ |

DOCUMENTATION TEMPLATE FOR PHYSICAL THERAPIST PATIENT/CLIENT MANAGEMENT

Systems Review

CARDIOVASCULAR/PULMONARY SYSTEM

Heart rate: _____

Respiratory rate: _____

Blood pressure: _____

Edema: _____

INTEGUMENTARY SYSTEM

Integrity

Pliability (texture): _____

Presence of scar formation: _____

Skin color: _____

Skin integrity: _____

**COMMUNICATION, AFFECT, COGNITION,
LEARNING STYLE**

Communication (eg, age-appropriate) Not Impaired Impaired

Orientation x 3 (person/place/time) Not Impaired Impaired

Emotional/behavioral responses Not Impaired Impaired

Learning barriers:

None

Vision

Hearing

Unable to read

Unable to understand what is read

Language/needs interpreter

Other: _____

MUSCULOSKELETAL SYSTEM

Gross Symmetry Not Impaired Impaired

Standing: _____

Sitting: _____

Activity specific: _____

Gross Range of Motion Not Impaired Impaired

Gross Strength Not Impaired Impaired

Other: _____

Height _____

Weight _____

NEUROMUSCULAR SYSTEM

Gross Coordinated Movements

Balance Not Impaired Impaired

Gait Not Impaired Impaired

Locomotion Not Impaired Impaired

Transfers Not Impaired Impaired

Transitions Not Impaired Impaired

Motor function (motor control, motor learning) Not Impaired Impaired

Education needs:

Disease process

Safety

Use of devices/equipment

Activities of daily living

Exercise program

Other: _____

How does patient/client best learn? Pictures Reading Listening Demonstration Other: _____

**DOCUMENTATION TEMPLATE FOR
PHYSICAL THERAPIST PATIENT/CLIENT MANAGEMENT
Plan of Care**

Anticipated Goals: _____

Expected Outcomes: _____

Interventions: _____

Frequency of Visits/Duration of Episode of Care: _____ _____ _____
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Education (including safety, exercise, and disease information): _____

Who was educated? Patient/client Family (name and relationship): _____

How did patient/family demonstrate learning:

- Patient/client verbalizes understanding
- Family/significant other verbalizes understanding
- Patient/client demonstrates correctly
- Demonstration is unsuccessful (describe): _____

Discharge Plan: _____

