DOCUMENTATION TEMPLATE FOR PHYSICAL THERAPIST PATIENT/CLIENT MANAGEMENT

Outpatient Form 1, Page 1

Today's Date: ____________
Patient ID#: ____________

Outpatient History

American Physical Therapy Association

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: ____________________

© American Physical Therapy Association 1999; revised September 2000, January 2002

22 MEDICAL/SURGICAL HISTORY

a Please check if you have ever had:

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

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

- (1) ☐ Chest pain
- (2) ☐ Heart palpitations
- (3) ☐ Cough
- (4) ☐ Hoarseness
- (5) ☐ Shortness of breath
- (6) ☐ Dizziness or blackouts
- (7) ☐ Coordination problems
- (8) ☐ Weakness in arms or legs
- (9) ☐ Loss of balance
- (10) ☐ Difficulty walking
- (11) ☐ Joint pain or swelling
- (12) ☐ Pain at night
- (13) ☐ Difficulty sleeping
- (14) ☐ Loss of appetite
- (15) ☐ Nausea/vomiting
- (16) ☐ Difficulty swallowing
- (17) ☐ Bowel problems
- (18) ☐ Weight loss/gain
- (19) ☐ Urinary problems
- (20) ☐ Fever/chills/sweats
- (21) ☐ Headaches
- (22) ☐ Hearing problems
- (23) ☐ Vision problems
- (24) ☐ 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?
(1) ☐ Yes (2) ☐ No

f Endometriosis?
(1) ☐ Yes (2) ☐ No

g Trouble with your period?
(1) ☐ Yes (2) ☐ No

h Complicated pregnancies or deliveries?
(1) ☐ Yes (2) ☐ No

i Pregnant, or think you might be pregnant?
(1) ☐ Yes (2) ☐ No

j Other gynecological or obstetrical difficulties?
(1) ☐ Yes (2) ☐ No
If yes, please desribe:________

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)? Month ☐☐ Year ☐☐☐☐

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) ☐ Acupuncturist
- (2) ☐ Cardiologist
- (3) ☐ Chiropractor
- (4) ☐ Dentist
- (5) ☐ Family practitioner
- (6) ☐ Internist
- (7) ☐ Massage therapist
- (8) ☐ Neurologist
- (9) ☐ Obstetrician/gynecologist
- (10) ☐ Occupational therapist
- (11) ☐ Orthopedist
- (12) ☐ Osteopath
- (13) ☐ Pediatrician
- (14) ☐ Podiatrist
- (15) ☐ Primary care physician
- (16) ☐ Rheumatologist
- Other:____________________

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
  - (b) ☐ on stairs
  - (c) ☐ on ramps
  - (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) ☐ Advil/Aleve
- (2) ☐ Antacids
- (3) ☐ Ibuprofen/Naproxen
- (4) ☐ Antihistamines
- (5) ☐ Aspirin
- (6) ☐ Decongestants
- (7) ☐ Herbal supplements
- (8) ☐ Tylenol
- (9) ☐ Other:________________
____
____

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

© American Physical Therapy Association 1999; revised September 2000, January 2002

DOCUMENTATION TEMPLATE FOR PHYSICAL THERAPIST PATIENT/CLIENT MANAGEMENT

Systems Review

American Physical Therapy Association

	Not Impaired	Impaired
CARDIOVASCULAR/PULMONARY SYSTEM	☐	☐
Heart rate: ______		
Respiratory rate: ______		
Blood pressure: ______		
Edema: ______		
INTEGUMENTARY SYSTEM	☐	☐
Integrity		
Pliability (texture): ______		
Presence of scar formation: ______		
Skin color: ______		
Skin integrity: ______		

	Not Impaired	Impaired
MUSCULOSKELETAL SYSTEM		
Gross Symmetry	☐	☐
Standing: ______		
Sitting: ______		
Activity specific: ______		
Gross Range of Motion	☐	☐
Gross Strength	☐	☐
Other: ______		

Height ______

Weight ______

	Not Impaired	Impaired
NEUROMUSCULAR SYSTEM		
Gross Coordinated Movements		
Balance	☐	☐
Gait	☐	☐
Locomotion	☐	☐
Transfers	☐	☐
Transitions	☐	☐
Motor function (motor control, motor learning)	☐	☐

	Not Impaired	Impaired
COMMUNICATION, AFFECT, COGNITION, LEARNING STYLE		
Communication (eg, age-appropriate)	☐	☐
Orientation x 3 (person/place/time)	☐	☐
Emotional/behavioral responses	☐	☐

Learning barriers:

- ☐ None
- ☐ Vision
- ☐ Hearing
- ☐ Unable to read
- ☐ Unable to understand what is read
- ☐ Language/needs interpreter
- ☐ Other: ______

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: ______

© American Physical Therapy Association 1999; revised September 2000, January 2002

DOCUMENTATION TEMPLATE FOR PHYSICAL THERAPIST PATIENT/CLIENT MANAGEMENT

Tests and Measures

KEY TO TESTS AND MEASURES:

1 Aerobic Capacity/Endurance
2 Anthropometric Characteristics
3 Arousal, Attention, and Cognition
4 Assistive and Adaptive Devices
5 Circulation (Arterial, Venous, Lymphatic)
6 Cranial and Peripheral Nerve Integrity
7 Environmental, Home, and Work (Job/School/Play) Barriers
8 Ergonomics and Body Mechanics
9 Gait, Locomotion, and Balance
10 Integumentary Integrity
11 Joint Integrity and Mobility
12 Motor Function (Motor Control and Motor Learning)
13 Muscle Performance (Including Strength, Power, and Endurance)
14 Neuromotor Development and Sensory Integration
15 Orthotic, Protective, and Supportive Devices
16 Pain
17 Posture
18 Prosthetic Requirements
19 Range of Motion (Including Muscle Length)
20 Reflex Integrity
21 Self-Care and Home Management (Including Activities of Daily Living and Instrumental Activities of Daily Living)
22 Sensory Integrity
23 Ventilation and Respiration/Gas Exchange
24 Work (Job/School/Play), Community, and Leisure Integration or Reintegration (Including Instrumental Activities of Daily Living)

NOTES:

© American Physical Therapy Association 1999; revised September 2000, January 2002

DOCUMENTATION TEMPLATE FOR PHYSICAL THERAPIST PATIENT/CLIENT MANAGEMENT

Evaluation

DIAGNOSIS:

Musculoskeletal Patterns

- ☐ A: Primary Prevention/Risk Reduction for Skeletal Demineralization
- ☐ B: Impaired Posture
- ☐ C: Impaired Muscle Performance
- ☐ D: Impaired Joint Mobility, Motor Function, Muscle Performance, and Range of Motion Associated With Connective Tissue Dysfunction
- ☐ E: Impaired Joint Mobility, Motor Function, Muscle Performance, and Range of Motion Associated With Localized Inflammation
- ☐ F: Impaired Joint Mobility, Motor Function, Muscle Performance, Range of Motion, and Reflex Integrity Associated With Spinal Disorders
- ☐ G: Impaired Joint Mobility, Muscle Performance, and Range of Motion Associated With Fracture
- ☐ H: Impaired Joint Mobility, Motor Function, Muscle Performance, and Range of Motion Associated With Joint Arthroplasty
- ☐ I: Impaired Joint Mobility, Motor Function, Muscle Performance, and Range of Motion Associated With Bony or Soft Tissue Surgery
- ☐ J: Impaired Motor Function, Muscle Performance, Range of Motion, Gait, Locomotion, and Balance Associated With Amputation

Neuromuscular Patterns

- ☐ A: Primary Prevention/Risk Reduction for Loss of Balance and Falling
- ☐ B: Impaired Neuromotor Development
- ☐ C: Impaired Motor Function and Sensory Integrity Associated With Nonprogressive Disorders of the Central Nervous System—Congenital Origin or Acquired in Infancy or Childhood
- ☐ D: Impaired Motor Function and Sensory Integrity Associated With Nonprogressive Disorders of the Central Nervous System—Acquired in Adolescence or Adulthood
- ☐ E: Impaired Motor Function and Sensory Integrity Associated With Progressive Disorders of the Central Nervous System
- ☐ F: Impaired Peripheral Nerve Integrity and Muscle Performance Associated With Peripheral Nerve Injury
- ☐ G: Impaired Motor Function and Sensory Integrity Associated With Acute or Chronic Polyneuropathies
- ☐ H: Impaired Motor Function, Peripheral Nerve Integrity, and Sensory Integrity Associated With Nonprogressive Disorders of the Spinal Cord
- ☐ I: Impaired Arousal, Range of Motion, and Motor Control Associated With Coma, Near Coma, or Vegetative State

Cardiovascular/Pulmonary Patterns

- ☐ A: Primary Prevention/Risk Reduction for Cardiovascular/Pulmonary Disorders
- ☐ B: Impaired Aerobic Capacity/Endurance Associated With Deconditioning
- ☐ C: Impaired Ventilation, Respiration/Gas Exchange, and Aerobic Capacity/Endurance Associated With Airway Clearance Dysfunction
- ☐ D: Impaired Aerobic Capacity/Endurance Associated With Cardiovascular Pump Dysfunction or Failure
- ☐ E: Impaired Ventilation and Respiration/Gas Exchange Associated With Ventilatory Pump Dysfunction or Failure
- ☐ F: Impaired Ventilation and Respiration/Gas Exchange Associated With Respiratory Failure
- ☐ G: Impaired Ventilation, Respiration/Gas Exchange, and Aerobic Capacity/Endurance Associated With Respiratory Failure in the Neonate
- ☐ H: Impaired Circulation and Anthropometric Dimensions Associated With Lymphatic System Disorders

Integumentary Patterns

- ☐ A: Primary Prevention/Risk Reduction for Integumentary Disorders
- ☐ B: Impaired Integumentary Integrity Associated With Superficial Skin Involvement
- ☐ C: Impaired Integumentary Integrity Associated With Partial-Thickness Skin Involvement and Scar Formation
- ☐ D: Impaired Integumentary Integrity Associated With Full-Thickness Skin Involvement and Scar Formation
- ☐ E: Impaired Integumentary Integrity Associated With Skin Involvement Extending Into Fascia, Muscle, or Bone and Scar Formation

PROGNOSIS: ____

© American Physical Therapy Association 1999; revised September 2000, January 2002

DOCUMENTATION TEMPLATE FOR PHYSICAL THERAPIST PATIENT/CLIENT MANAGEMENT

Plan of Care

Plan of Care

American Physical Therapy Association

Anticipated Goals: ______

Expected Outcomes: ______

Interventions: ______

Frequency of Visits/Duration of Episode of Care: ______

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: ______

© American Physical Therapy Association 1999; revised September 2000, January 2002