

Carelink Health Care Services, LLC

PHYSICAL THERAPY EVALUATION

Patient: _____ M/R #: _____

DX: _____

	STRENGTH		ROM		FUNCTIONAL STATUS		SENSATION	
	L	R	L	R	Rolls in bed		PROPRIOCEPTION	
SHOULDER FLEXION					Supine ↔ Sit		MUSCLE TONE	
ABDUCTION					Sitting Balance		SKIN	
INT. ROTATION					Sit ↔ Stand		SPEECH	
EXT. ROTATION					Bed ↔ Chair		VISION	
ELBOW FLEXION					W/C Mobility		HEARING	
EXTENSION					Stand Dynamic Balance		Coding: I = Independent w/o assistive device Mod I = Independent w/ assistive device S= Supervision Min 25% assistance required Mod = 50%-75% assistance required Max = > 75% assistance required	
SUPINATION					Stand Static Balance			
WRIST FLEXION					Gait:			
EXTENSION					distance:			
FINGER FLEXION					device:			
EXTENSION					assistance:			
THUMB FLEXION					Stairs / Ramp			
EXTENSION					H&P/ D/C SUMMARY			
HIP FLEXION								
EXTENSION								
ABDUCTION								
INT. ROTATION								
EXT. ROTATION								
KNEE FLEXION								
EXTENSION								
ANKLE DORSI								
PLANTAR					PRIOR FUNCTION:			
INVERSION								
EVERSION					PAST MED. HX:			
EDEMA								
Site:								
HOME EVALUATION: _____					FUNCTIONAL TESTING: _____			
PRECAUTIONS/CONTRAINDICATIONS: _____					TREATMENT PLAN/PLAN OF CARE			
STG's: _____								

LTG's: _____					DISCHARGE PLANS: _____			

Rehab. Potential: <i>poor</i> <i>guarded</i> <i>fair</i> <i>good</i> <i>excellent</i> Patient has been involved in plan of care: <i>yes</i> <i>no</i> Frequency: _____ In my judgement the above named patient is "homebound" YES NO					Physician Name: _____			
Therapist Signature: _____					Date: _____			

Patient Signature:

Date: