APPENDIX B: *Guide to Physical Therapist Practice* Template

Documentation of history may include the following:

- General demographics
- Social history
- Employment/work (job/school/play)
- Growth and development
- Living environment
- General health status (self-report, family report, caregiver report)
- Social/health habits (past and current)
- Family history
- Medical/surgical history
- Current condition(s)/chief complaint(s)
- Functional status and activity level
- Medications
- Other clinical tests

Documentation of systems review may include gathering data for the following systems:

Cardiovascular/pulmonary

- ✓ Blood pressure
- ✓ Edema
- ✓ Heart rate
- ✓ Respiratory rate

Integumentary

- ✓ Pliability (texture)
- ✓ Presence of scar formation
- ✓ Skin color
- ✓ Skin integrity

Musculoskeletal

- ✓ Gross range of motion
- ✓ Gross strength
- ✓ Gross symmetry
- ✓ Height
- ✓ Weight

Neuromuscular

- ✓ Gross coordinated movement (e.g., balance, locomotion, transfers, and transitions)
- ✓ Motor function (motor control, motor learning)

Documentation of systems review may also address communication ability, affect, cognition, language, and learning style:

- ✓ Ability to make needs known
- ✓ Consciousness
- ✓ Expected emotional/behavioral responses
- ✓ Learning preferences (e.g., education needs, learning barriers)
- ✓ Orientation (person, place, time)

Documentation of tests and measures may include findings for the following categories:

- Aerobic capacity/endurance
- Anthropometric characteristics
- Arousal, attention, and cognition
- Assistive and adaptive devices
- Circulation (arterial, venous, lymphatic)
- Cranial and peripheral nerve integrity
- Environmental, home, and work (job/school/play) barriers
- Ergonomics and body mechanics
- Gait, locomotion, and balance
- Integumentary integrity
- Joint integrity and mobility
- Motor function
- Muscle performance
- Neuromotor development and sensory integration
- Orthotic, protective, and supportive devices
- Pain
- Posture
- Prosthetic requirements
- Range of motion (including muscle length)
- Reflex integrity
- Self-care and home management (including activities of daily living and instrumental activities of daily living)
- Sensory integrity
- Ventilation and respiration
- Work (job/school/play), community, and leisure integration or reintegration (including instrumental activities of daily living)

Documentation of each visit/encounter shall include the following elements:

- Patient/client self-report (as appropriate).
- Identification of specific interventions provided, including frequency, intensity, and duration as appropriate
- Changes in patient/client impairment, functional limitation, and disability status as they relate to the plan of care.
- Response to interventions, including adverse reactions, if any.
- Factors that modify frequency or intensity of intervention and progression goals, including patient/client adherence to patient/client-related instructions.
- Communication/consultation with providers/patient/client/family/ significant other.
- Documentation to plan for ongoing provision of services for the next visit(s)

Documentation of reexamination shall include the following elements:

- Documentation of selected components of examination to update patient's/client's impairment, function, and/or disability status.
- Interpretation of findings and, when indicated, revision of goals.
- When indicated, revision of plan of care, as directly correlated with goals as documented.

Documentation of discharge or discontinuation shall include the following elements:

- Current physical/functional status.
- Degree of goals achieved and reasons for goals not being achieved.
- Discharge/discontinuation plan related to the patient/client's continuing care.

Examples include:

Home program.
Referrals for additional services.
Recommendations for follow-up physical therapy care.
Family and caregiver training.
Equipment provided.