PHYSICAL THERAPY HOME EVALUATION

2497 State Road Cuyahoga Falls, Oh 44223 Phone: 330-929-5512 Fax: 330-929-7732

Patient Name _____ D.O.B. _____/_____/_____ ☐ Male ☐ Female
Address _____ Phone _____
Caretaker Name & Phone _____
Resides with: ☐ lives alone ☐ spouse ☐ parent ☐ child ☐ other_____
Physician _____ Physician Phone_____
Diagnosis/Chief Complaint_____
Dr. Orders _____

_____
Pertinent Medical/Surgical History_____

_____
Previous Functional Level _____

Mental Status: *(check appropriate status)*
☐ Agitated ☐ Impulsive ☐ Belligerent ☐ Confused ☐ Fearful ☐ Hostile ☐ Demanding
☐ Forgetful ☐ Alert ☐ Oriented ☐ Cooperative ☐ Motivated ☐ Risk of falls ☐ Follows Instructions
Intervention:

DME within home: *(check appropriate status)*
☐ Walker ☐ Cane ☐ WBQC ☐ SBQC ☐ Crutches ☐ W/C ☐ BSC
☐ Hospital Bed ☐ Trapeze ☐ Tub Bench ☐ Other _____
Orthotic / Prosthetic _____
Intervention:

Gait Status:
☐ Asst. Device ☐ WB Status ☐ Asst Req ☐ Orthotic ☐ Balance ☐ Endurance ☐ Deviations
Ambulation assistance ☐ minimum ☐ moderate ☐ maximum ☐ unable – reason _____
Intervention:

Functional Limitations: *(check appropriate areas)*
☐ Amputation ☐ Contracture ☐ Spasm ☐ Hearing ☐ Vision ☐ Speech ☐ SOB
☐ Endurance ☐ Weakness ☐ Pain ☐ Paralysis/Paresis ☐ Other:

Transfer Ability: *Assist Definition* – MIN <50% by PT/CG MOD 50-75% MAX 100% CG = Safety / cuing

	Independent	CG	SUP	Assist	Depend	Comments
Rolling	☐	☐	☐	☐	☐	_____
Supine to sit	☐	☐	☐	☐	☐	_____
Sit to Stand	☐	☐	☐	☐	☐	_____

Safety Awareness / Body Mechanics / Cuing _____
Intervention: ☐ Transfer training ☐ Other_____

Balance: *(check appropriate level)*

	WNL	GOOD	FAIR	POOR	UNABLE TO ASSESS	Comments
Sitting	☐	☐	☐	☐	☐	_____
Standing	☐	☐	☐	☐	☐	_____
Dynamic Stand	☐	☐	☐	☐	☐	_____

Posture: (check appropriate level) ☐ WNL ☐ Kyphotic ☐ Lordotic ☐ Scoliosis ☐ Other _____
Intervention/goal:

Patient Name _____

	Shoulder	Elbow	Wrist	Grasp	Hip	Knee	Ankle	Trunk
ROM (r)								
ROM (l)								
Strength (0/5 – 5/5 scale)								

Neurological: *(check applicable areas)*
☐ WNL ☐ Paresis / Paralysis ☐ Abnormal Tone ☐ Proprioception: Deficits_____

Sensation: *(check applicable areas)* ☐ WNL ☐ Deficits: _____

☐ Pain Location _____ Level: 0 ——— 10
☐ Edema Location _____ Severity _____ Type _____

Comments: _____

Reason for Homebound Status: *(check appropriate areas)*

☐ Limited Ambulation Tolerance (____ ft.) ☐ Poor Endurance ☐ Dyspnea ☐ Requires Assistance to leave home
☐ Impaired Cognitive Status ☐ Unable to negotiate stairs ☐ Med Restrict. ☐ Other _____

Social Concerns or Limitations:

☐ Patient ☐ Spouse ☐ Family ☐ Caregiver ☐ Aide ☐ RN ☐ None
Comments:

Safety Concerns:

☐ Stairs ☐ Inside ☐ Outside ☐ Railings ☐ Ramp ☐ Lighting
☐ Phone Access ☐ W/C Accessible ☐ Life-line ☐ Bathroom Safety

P.T Treatment Codes / Needed Services: *(check appropriate treatments)*

☐ 1 – Evaluation ☐ 2 – Ther. Exercises ☐ 3 – Transfer Training ☐ 4 – Establish/Teach/Upgrade Home Ex Program
☐ 5 – Gait Training ☐ 6 – Cardiac Rehab ☐ 7 – Ultrasound ☐ 8 – Electrotherapy
☐ 9 – Prosthetic Training ☐ 10 – Other _____

Discharge Plans: *(check appropriate plan)*
☐ To Self-care ☐ To Caregiver ☐ To outpatient P.T. ☐ Other _____
Pt / Caregiver involved in goals ☐ Yes ☐ No POC discussed with: ☐ PTA ☐ OT ☐ RN ☐ MD ☐ MSW ☐ Other

Additional Comments_____

_____

_____

_____

_____

PT Signature _____ License # _____ Date _____
Time In _____ Time Out _____