APTA GUIDE FORMAT FOR DAILY TX NOTES:

- Patient Information:
  - current status: pn level, changes since last visit, compliance with tx plan
  - objective self-report measures including: VRS for pain, % usu function, % improvement, activity tolerance

- Tests and Measures

- Intervention

- Evaluation:
  - summarize the pt's progress toward goals
  - make judgments about the tests and measures you’ve done
  - describe changes in therapy intervention
  - describe reason for needed changes in plan

- Intervention Plan (only update as needed)
  - Update outcomes/goals/prognosis
  - Update frequency/duration of therapy
  - Plan for future communication/coordination
  - Plan for future pt instruction
  - Plan for adding/changing specific interventions in upcoming txs

INITIAL EXAMINATION OUTLINE:

I. History / Patient Self-Report / Patient Information

A. Patient Profile: demographic info, occupation, behavioral/cognitive status, manner by which physical therapy services were initiated, reason for referral/CC, manner of referral

B. Account of Current Condition: HPI, MOI, Evaluations, Dx tests, date of onset, tx/course of events since onset, past history of current condition (any related/similar episodes), Medications – OTC or MD Rx, any benefit for current problem, taking as directed, med schedule, dx tests: dates/timing & results

C. Symptoms: LOCIDAA+

D. Current Function/Disability: standardized questionnaires

E. PMH, health Risk Factors: Other Medical Care / hospitalizations or serious illness, Pregnancy, Family history, Potential Red Flags

F. Other information: Personal and Environmental Factors, Pt goals, contraindications/precautions

II. Systems Reviews: Cardiopulmonary, Neuromuscular, Integumentary, Musculoskeletal, Cognitive function

III. Tests and Measures
• Observation: *just what you see*
• ROM: joint clearing of adjacent joints, motion, quality, pt responses, end feel
• Flexibility: muscle or joint motion and descriptor (WNL, decreased, increased)
• Resisted Tests:
  o Describe mm or joint action, magnitude, anything else of note
  o If STTT testing, use terms such as SPL, SPF, WPF, WPL, mid/short/lengthened position
• Neuro Tests: Sensory (“intact” or “impaired”), Motor (normal/WNL or weak), DTR’s
• Special Tests
• Joint Mobility
• Palpation
• Functional Tests

IV. Today’s intervention & response to tx

V. Evaluation
A. Summary Statement
   → probable tissues at fault
   → hypothesis about underlying causes
   → acuity/irritability/severity of problem
   → may include APTA practice pattern, other diagnostic or tx-based classification
B. Problem list
   → Impairments
   → Functional Limitations

VI. Plan of Care
A. Outcomes / Anticipated STG / LTGs
   a. Goals are: pt oriented, objective/measurable, realistic for time frame, related
to 1 of 3 categories: fxn’l problems/disability identified in exam and/or
history; pt/client satisfaction; secondary prevention
B. Prognosis statement
C. Intervention plan
   a. Direct intervention (describe response to tx): Treatment schedule (frequency
and duration), Every possible future tx category, Plan for further
examination, Plan for equipment/supply needs (IF YOU HAVE ANY
ADDITIONAL SUPPLY NEEDS, BE SURE TO TELL THE STUDENT LIAISONS
WHO WILL BE IN TOUCH WITH OUR TREASURERS), Discharge plan
   b. Communication/coordination: plan for any communications with family,
patient, other providers, etc
   c. Patient/family education: may include caregivers, teachers, family, etc

VII. INFORMED CONSENT:
   o Must be included in initial exam documentation
   o Include in daily notes when changes to initial intervention plan occur
   o Parent/Guardian gives consent for minors