EXAMINATION

According to the American Physical Therapy Association (APTA), the initial examination is a "comprehensive screening and specific testing process leading to diagnostic classification and/or as appropriate, to a **referral** to another practitioner" (2011, p10). The **examination** consists two sections, the **history** with **systems review** and the **tests and measures** - and it must be performed on *all* patients and prior to the provision of treatment (APTA, 2011, p10).

Do not be confused by the term **history** because, according to the APTA, it consists of data from both the **past and present** (2011, p10). The ATPA describes the **systems review** as "a brief or limited examination of: (1) the anatomical and physiological status of the patient's/client's cardiovascular / pulmonary, integumentary, musculoskeletal, and neuromuscular systems; (2) ability, affect, cognition, language, psycho-emotional status (e.g., self-efficacy and motivation), and learning style of the patient/client, (3) review the **red flags** and other screening data… Using the data from the **history and systems review**, the physical therapist generates diagnostic hypotheses that he or she further investigates by specific tests and measures. These tests and measures are used to rule in or rule out the presence of and links between impairments in the patient's /client's body functional and structure, activity limitations, and participating restrictions; to establish a diagnosis, prognosis, and plan of care; and to select interventions" (2011,p10).

Because APTA's definition of a systems review is a brief examination or a limited examination, we will use these three terms interchangeably. And because the verb 'screen' is arguably commonly used by physical therapists in accordance with its definition "to test or examine for the presence of something (such as a disease)" (Miriam-Webster, n.d.), we will consider **screen** a synonym of brief examination, limited examination, and systems review.

A **screen** can be verbal, visual, or in a written format. An example of a **verbal screen** is asking a patient to rate her pain on a scale of one to ten. A verbal screen can also be quite informal, such as "Have you had any pain today?" A visual screen is when you carefully observe a patient's action. An example of a **visual screen** is pointing to a patient's home exercise program paper and directing him "Please show me how you have been doing this first exercise." A **written screen** is perhaps more often used in an outpatient setting, for instance, when a patient is seated in the waiting room and is given a handout and asked to answer the few questions on it.

HOLISTIC EXAMINIATION OF THE MENTAL AND SOCIAL COMPONENTS OF HEALTH

As physical therapists, we are well trained in examining the 'physical' elements of a patient, that is, the anatomical, physiological, cardiovascular, pulmonary, integumentary, musculoskeletal, and neuromuscular systems. In contrast, it can be argued that our ability to examine the mental and social components of a patient **health** is less than ideal. One goal of holistic physical therapist patient management is to ensure the examination of the mental and social components of the patient is adequate and not 'short changed.' The mental elements the APTA specifically identifies are **language**, **cognition**, psycho-emotional status, affect, and learning style. **Psycho-emotional status** is analogous to **mood** (how a person feels), while **affect** is the expression of a mood (Martin, 1990). Both mood and affect can be described as euthymic (WNL including normal 'ups and downs'), dysphoric (guilt, anxiety, depression) or euphoric (Martin, 1990). Both mood and affect can also be labile (uncontrollable and inappropriate reaction to a situation such as laughing at a funeral) (Martin, 1990). A pathological dysphoric, euphoric, or labile mood and affect are usually symptoms of an untreated or poorly

used "as is," it is typically more appropriate to modify them to best fit the particular patient and situation.

We will now practice using the **Health Measures** tool to examine some of the mental and social components of a patient's chronic pain. We'll name our mock patient Mark. To begin, visit the **Health Measures** website, which is provided in the **Textbook Supplement** at WellnessSociety.org. Next, select **Adult** for the Age, **All** for the Category, **Self-Efficacy for Managing Chronic Conditions** for the Domain, **All** for the Measure Type, **All** for the Measurement System, **All** for the Administration Platform, and **English** for the Language. Your search will yield 15 results related to a patient's self-efficacy in managing chronic conditions. I will use some of the items to measure Mark's *self-efficacy* in his ability to manage his pain and I will modify other items to measure his *actual* ability manage his pain. Of the 15 results, please select the third one, "PROMIS… Self-Efficacy for Managing Medications and Treatments," and then, under "View Measure," click on the form itself to download a list of items you can use to examine Mark's self-efficacy for managing his chronic pain medications. For example, you might ask him, "Do you remember to take your pain medications as prescribed?" "What pain medication do you take – including the dose, and when do you take it?" "Are you following your full treatment plan – including your pain medication, your relaxation exercises, and your home exercise program?" Next, go back and click the fourth result, "PROMIS…Self-Efficacy for Managing Social Interactions." From this list you might ask Mark, "Have you been able to stay involved with your Chess club group?" (Or, better yet, "Has your pain prevented you from meeting your friend to play chess recently?") "When you need it, do you get any emotional support for your pain?" "How confident are you that you're communicating well with your physician about your pain?" "How confident are you that your physician is listening to your needs?" The following two case scenarios, **Case Scenario 3-1.4. Rachel, DPT** and **Case Scenario 3-1.5. Peter, DPT,** respectively illustrate a physical therapist who is successfully obtaining patient self-report and another physical therapist who is not. The successful encounter is in part due to the integration of **Health Measures**!

CASE SCENARIO 3-1.4. Rachel, DPT

Dr. Rachel is a home health physical therapist. Early on in her Evaluation visit with new patient Roger Hoover, she measures his vitals.

He is afebrile, heart rate 75 bts/min and regular rhythm, respiration rate is 18 breaths/min and not labored, oxygen saturation is 97%, blood pressure is 157/98 mmHg on the left arm. Because the reading is elevated, she also measures it on his right arm, and the reading is 160/100 mmHg. Rachel had reviewed Roger's chart and recalls he has a comorbidity of hypertension and has been prescribed two antihypertensive medications. Rachel asks Roger: "Did you take your blood pressure pills his morning?" (Health Measures: PROMIS-Cognitive Function – Abilities Subset, item PC27r). Roger's reply will lead Rachel to her next question. For example, if Roger replies, "No, to be honest, I haven't taken any," Rachel might ask him, "Is taking your pills important

has only had six hours sleep each of the past two nights because he's stayed up too late watching television); he has had a **relapse** in proper nutritional practices (i.e., he hasn't put any effort into eating healthy for over a month); and he is the **Permanent Compliance** stage with good oral hygiene practices (i.e., brushes and flosses his teeth twice daily and has bi-annual dental exams and cleanings).

Regarding a particular patient's specific health behavior, such as compliance with their physical therapy home exercise program (HEP), there are many interventions and strategies a physical therapist can employ to progress a patient from incognizance to awareness, awareness to contemplation, contemplation to action & compliance, minimize lapses, reduce the risk of relapses, get them 'back on track' when they have a lapse or relapse, and perhaps even help them achieve the permanent maintenance stage. Integrated into our exploration of the stages of wellness, we will examine and apply three such interventions **Brief Teach**, **Guided Exploration**, and **Motivational Education** (**ME**).

STAGE OF WELLNESS: INCOGNIZANCE

If a patient is in the Stage of **Incognizance**, he does not understand that his behavior is unhealthy or 'wrong.' Or, he has flicker of understanding, but ignores or suppresses it. A symbol of a person in this stage is man with his head in the sand.

When one of your patients is in the Incognizance Stage of a healthy behavior then your first goal must be to facilitate the patient's recognition of the deficit. Until this is accomplished, the journey towards high-level wellness of a healthy behavior cannot occur. Progressing a patient from Incognizance to Awareness can be a daunting endeavor. To increase the likelihood that you can help a patient 'remove his head from the sand' and acknowledge he has a problem, you are more likely to have success if you teach to him in multiple learning styles, to include his preferred learning style. For example, if you have determined she is an intrapersonal learner, provide her points to consider, review, or analyze in the form of a written pamphlet and a few introductory words to the pamphlet. This brief intervention is aptly named "**Brief Teach**." (Detailed in **Case 3-2.3**. **Jafari and Brief Teach** on page 56.)

In some cases, it is beneficial to elicit help from a family member, a friend of the patient, and/or a paid caregiver. Involving others is essential in the pediatric and hospice settings, and often indicated in the acute, sub-acute, home health, assistive living facility (ALF), skilled nursing facility (SNF). Due to the nature of the outpatient setting, it is less frequent a patient's family, friends, or caregivers will participate. Sometimes, a patient is locked in the Incognizance Stage of a health behavior with a group of people: a group of friends who live in the same ALF get together daily to gossip or play cards, but never spend any of their time together going for a walk or attending any of the free exercise classes offered by the facility. If there is not an external stimulus to get one of the group members to begin to realize that exercise is missing from their lives, then all members of the group might continue their sedentary lifestyle indefinitely.
Case 3-2.2. **Dr. Hopkins – Stage of Incognizance** recounts an actual encounter with a patient who presented to me with his head in the sand.