Integrated Manual Physical Therapy

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ASSESSMENT OF PROGRESS:

Name:_____ Date of Birth:_____
Cell Phone:( )_____ Email:_____

PLEASE LIST ANY CHANGES TO YOUR HEALTH, NEW DIAGNOSES, OR SURGERIES:_____

_____

LIST ALL MEDICATIONS OR SUPPLEMENTS YOU ARE TAKING:

_____

_____

PLEASE REPORT YOUR OVERALL IMPROVEMENT WITH CARE AT IMPT:_____**% OVERALL**

WHAT COMPLAINTS OR SYMPTOMS HAVE CHANGED SINCE STARTING WITH IMPT?

_____

WHAT AREAS DO YOU STILL WANT TO WORK ON AT IMPT? DO YOU WANT TO CONTINUE CARE AT IMPT? WHAT ARE YOUR GOALS?

_____

PLEASE CIRCLE ANY NEW OR CURRENT AREAS OF PAIN OR SYMPTOMS:

Lower/middle/upper back Neck Head Jaw Abdomen Tailbone Pelvic region Ribs Shoulders

Elbows Wrist/Hands Carpal tunnel Hips Knees Feet Plantar fasciitis Sciatica

CURRENT PAIN RATING? **(No pain) 1 2 3 4 5 6 7 8 9 10 (Extreme pain)**

CIRCLE ALL THE WORDS THAT DESCRIBE YOUR SYMPTOMS:

Numbness Tingling Stabbing Burning Aching Throbbing Tender Shooting Sharp Constant Intermittent Other_____

CIRCLE ALL THE ACTIVITIES THAT YOU STILL HAVE DIFFULCUTY WITH:

Sleep Sitting Getting up from sitting Standing Walking Exercise Self-care/Grooming Dressing Household chores Other_____

PLEASE LIST WHAT MAKES YOUR SYMPTOMS BETTER:

_____

PLEASE LIST WHAT MAKES YOUR SYMPTOMS WORSE:

_____

WHAT IS YOUR CURRENT HOME EXERCISE PROGRAM? WHAT SELF-CARE ARE YOU DOING?

_____

CURRENT FUNCTION RATING? **(Barely functioning) 1 2 3 4 5 6 7 8 9 10 (Fully functioning)**

PROGRESS NOTE **DATE**_____
NAME_____**DOB**_____
CURRENT COMPLAINTS AND SUBJECTIVE STATUS

_____
_____
_____

FUNCTIONAL MOBILITY AND CURRENT OBJECTIVE STATUS
PROM THORACIC ROT R=_____ L=_____PROM SHOULDER ABD (palm down) R=_____ L=_____
SUPINE HIP IR R=_____ L=_____ ER R=_____ L=_____
OTHER A/PROM_____
FUNCTIONAL SQUAT B_____ LPM (FLEXION FOOT FORWARD) R=_____L=_____
SIT SLUMP TEST FLEXION R=_____L=_____ EXTENSION BIAS R=_____L=_____
MNTT R=_____L=_____ RNTT R=_____ L=_____
SPECIAL TESTS:_____
PALPATION_____
MYOTOMAL: HIP/SHOULDER FLEXION R=_____/5 L=_____/5 ABDUCTION R=_____/5 L=_____/5
EXT R=_____/5 L=_____/5 IR R=_____/5 L=_____/5 ER R=____/5 L=____/5 **ELBOW/KNEE** FLEX R=____/5
L=____/5 EXT R=_____ L=_____**WRIST/ANKLE** FLEX R= ____ L= ____ EXT R=____/5 L=_____/5
OTHER
_____

ASSESSMENT AND PROGRESS TOWARD GOALS:

_____
_____

REVISED GOALS:

_____
_____
_____

PLAN:
☐ Recommend discontinue physical therapy to self-management and HEP.
☐Recommend continue physical therapy. Patient will be seen on a _____x per week/month basis to address remaining physical deficits and functional limitations to meet goals. Patient is appropriate and will benefit from continued skilled physical therapy treatment to meet initial goals or any revised goals stated above.
☐ Due to moderate complexity of patient's condition, progress will be assessed in the next 6–8 visits.
☐ Due to significant complexity of patient's condition or co-morbidities, progress will be assessed in the next 8–12 visits.
☐ Patient will continue with a wellness, prevention, or maintenance-based program; progress will be assessed annually.
Treatment interventions may include any of the following: STM, MFR, joint, visceral mobilization, therapeutic exercises, home exercise program revisions, patient education on posture and body mechanics, PNF, neuro re-ed, use of cryotherapy, heat therapy, dynamic stretching, mobility exercises, breathing exercises, and/or other modalities deemed appropriate .

TODAY'S TREATMENT:

_____
_____
_____

HEP:

_____

POST-TREATMENT CHANGES:

_____
_____

THERAPIST SIGNATURE:_____DATE_____