

Patient: _____ Date: _____

© Z Form 1301-2 (PM&R ADL) revised 12/09/02

PHYSICAL EXAM: EP: (2=1-5 ele / 3>=6 ele / 4>=12 ele / 5>=18 ele)
NP: (1 = 1-5 ele / 2 = >=6 ele / 3 = >=12 ele (2+ sys) / 4-5 = >=18 (9 sys))

Vitals: T: _____ P: _____ R: _____ B/P: _____ Ht: _____ Wt: _____

Gen App: ___ WDWN Obese Thin Frail _____

Psych: ___ Oriented x3
___ Mood/Affect Normal
___ Judgment/Insight WNL
___ Recent/Remote Mem WNL
___ Appropriate Behavior

Neck: ___ Symmetrical
___ No Thyromegaly
___ No Bruit♥
___ Nontenderφ

Musc: ___ Gait/Station NI
___ No Calf Tenderness
___ Homan's Negative

UE Strength:	ROM:	
	Right	Left
Intact	<input type="checkbox"/>	<input type="checkbox"/>
Deltoids	_____	_____
Biceps	_____	_____
Wrist Exten	_____	_____
Triceps	_____	_____
Finger Flex	_____	_____
Intrinsics	_____	_____
	Shoulder	_____
	Elbow	_____
	Wrist	_____
	Hand	_____
	Hip	_____
	Knee	_____
	Ankle	_____

LE Strength:	Tone:	
	Right	Left
Intact	<input type="checkbox"/>	<input type="checkbox"/>
Hip Flex	_____	_____
Quads	_____	_____
Dorsiflex	_____	_____
EHL	_____	_____
Plantar Flex	_____	_____
	UE	_____
	LE	_____
	Coordination: Right	Left
	UE	_____
	LE	_____

Neuro: ___ CN II – XII Intact Exc: _____
___ No Sensory Def Noted
___ Speech/Language WFL
___ Attention Span WNL

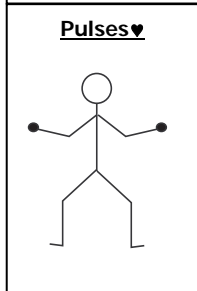
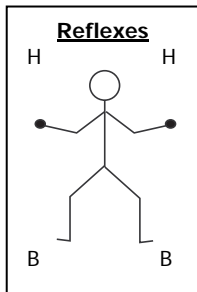
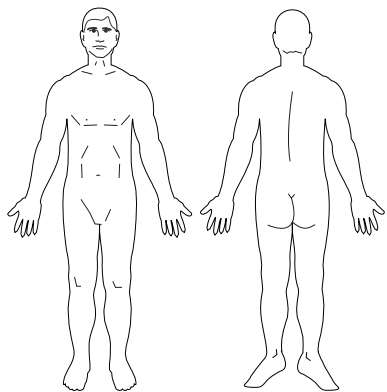


Diagram Key
T=Tenderness
Skin Breakdown As Drawn
[Hatched Box] = Altered Sensation

Skin: ___ No Lesions or Rashes □ See Diagram
___ No Induration
Surg Wnd: _____

E/ENT: ___ Pupils Equal
___ Conjunctivae NI
___ Hearing WFL
___ Oral Mucosa Moist
GI: ___ Soft, Nontender
___ No Hernia
___ No Hepatosplenomegaly
___ NABS
Resp: ___ CTA Wheezing Rales Rhonchi
___ Breathing Unlabored
CVS:♥ ___ S1, S2
___ No Edema BLE
___ BLE Pulses Intact

RADIOLOGY REVIEWED: Report Film
Date: _____
LABS REVIEWED:
Date: _____
MEDICAL TESTS REVIEWED: Therapy Notes Reviewed
Date: _____

Review Old Records &/or Discuss w/Other Health Care Provider
Discussed w/ _____

CLINICAL IMPRESSION: (Stable / Improving / Worsening)
ADL Dysfunction 2nd to _____ Stable Imp Worse
Gen Decondition 2nd to _____ Stable Imp Worse
Gen Weakness 2nd to _____ Stable Imp Worse
Gait Dysfunction 2nd to _____ Stable Imp Worse
Difficulty Walking 2nd to _____ Stable Imp Worse

PLAN:
Discussion/To Consider: _____

*Records Ordered: _____
*Medication Trial: _____
*Refill/Continue Meds: _____

*Therapy RX/Continue: PT OT SLP Aquatics _____
*Radiology/Labs/Tests: _____
Equipment Ordered: _____
Ref to Dr./FU with: _____ Letter Dictated
Work Slip Given: Off Work Thru _____
 Light Duty Moderate Duty Return to Work
RTO: _____ Weeks / Months PRN DC

P.A.-C Signature _____ **Physician Signature** _____
Level: 1 2 3 4 5
 Discussed Case w/Physician Pt Seen By Physician Addendum Dictated

Visit Time: Time Began: _____ Time Finished: _____
 > 50% of Time Spent Counseling Pt on: Test Results / Therapy /
Meds / Activity / Diagnosis / Prognosis / _____

cc: _____

PM&R IN-PATIENT PROGRESS NOTE

(Guidelines require 4 elements of HPI for level 2 or 3)

DIAGNOSIS: _____

PROBLEM LIST: _____

PATIENT/NURSING CONCERNS: _____

- Pain Control (ROS: Neuro)
- Bladder Program (ROS: GU)
- Bowel Program (ROS: GI)
- Nutrition / Fluid Intake (ROS: Cons)

ONSET: _____

TIMING: _____

QUALITY: _____

SEVERITY: _____

MODIFYING FACTORS: _____

ASSOCIATED SIGNS AND SYMPTOMS: _____

PE: (31 = 1-5 elements; 32 = 6+ elements; 33 = 12+ elements)
(95 guidelines require 5-7 systems for level 3, 2-4 systems for level 2)

Vitals: T: _____ P: _____ R: _____ B/P: _____ Wt: _____

P Ox: _____ FS: _____

Gen App: ___ WDWN Obese Thin Frail

Skin: ___ No Rashes/Lesions
___ No Induration
Surgical Wound: _____

CVS: ___ S1, S2 (Reg Irreg)
___ No Edema BLE R: _____ L: _____
___ Pedal Pulses (Reg Irreg)

Pulm: ___ CTA
___ Breathing Unlabored

GI: ___ Nontender
___ No Hernia
___ *Normal Active Bowel Sounds*

Musc: ___ ROM – WFL x4
___ Tone – NI x4
___ Strength – WFL x4
___ *Homan's Neg BLE*
___ *No acute focal change*

Neuro: ___ CN II – XII Intact
___ No Sensory Deficit Noted

Psych: ___ Oriented x3
___ Mood/Affect NI
___ Judgment & Insight NI
___ *Appropriate Behavior*

- Case discussed with nursing Case discussed with therapy Case discussed with case management. Hospital records reviewed
- Reviewed / Ordered: Labs X-Rays Medical Tests

IMPRESSION/PLAN:

1. _____ stable/improved/worsening - _____
2. _____ stable/improved/worsening - _____
3. _____ stable/improved/worsening - _____
4. _____ stable/improved/worsening - _____

COMORBIDITIES

- Patient clinically stable to: Hold rehab program sec to:
- Continue rehab program
- Continue / adjust current prescription meds: _____
- Continue / adjust current anticoagulation: _____
- Continue / adjust current narcotics / analgesics: _____

NOTES:

Total Time of Exam/Med Mgmt/Chart Review: _____ Date: _____ Signature: _____

Level: 1 2 3

NEW PATIENT - ADL DYSFUNCTION/DIFFICULTY WALKING

PATIENT: _____ AGE: _____

SS#: _____ DATE: _____

Check Normals Circle/Write Positives Backslash (\) Negatives
CC / Reason For Visit: _____

Consult Req By: _____

HPI/IMPAIRMENT: (2 = 1-3 elements/3-5 = ≥4 or ≥3 chronic cond)

Context: CHF / Pneumonia / COPD Exacerbation / CVA
Parkinson's Disease / CABG / Other: _____

Onset: _____ Quality: Improving Getting Worse Same

Severity: (Effect on Functional Status)

Feeding	I	Mod I	Sup	Min	Mod	Max	Dep
Grooming	I	Mod I	Sup	Min	Mod	Max	Dep
Bathing	I	Mod I	Sup	Min	Mod	Max	Dep
Up Dressing	I	Mod I	Sup	Min	Mod	Max	Dep
Low Dressing	I	Mod I	Sup	Min	Mod	Max	Dep
Toileting	I	Mod I	Sup	Min	Mod	Max	Dep

Bed Mobility	I	Mod I	Sup	Min	Mod	Max	Dep
Chair/WC TX	I	Mod I	Sup	Min	Mod	Max	Dep
Toilet/Tub/Shower	I	Mod I	Sup	Min	Mod	Max	Dep
Ambulation Device	I	Mod I	Sup	Min	Mod	Max	Dep

Exacerbating Factors:

Exercise Walking
Stairs Lying Flat
Coughing Cold Temp
Heat / Humidity Nothing
Other: _____

Relieving Factors:

Rest Changing Position
Sitting Up Med: _____
Nothing
Other: _____

Associated Symptoms:

Chest Pain Weakness Fatigue SOB
Other: _____

CHRONIC CONDITIONS:

_____ stable/imp/worse
_____ stable/imp/worse
_____ stable/imp/worse

Physicians Seen: _____ - _____
For This Condition _____ - _____
Medication Trial: _____ Helped Didn't Help Didn't Take
_____ Helped Didn't Help Didn't Take
Current Therapy: PT OT SLP Aquatics Location: _____
Frequency: _____ x/week / Therapist: _____ HEP
D/C Therapy: PT OT SLP Aquatics D/C Date: _____
Equipment: Home: _____
Distances: _____
Recent Hosp: _____ Date: _____
Reason: _____

ROS: **Constitutional**

Weight Change
Fever / Chills
Sleep Disturb
Appetite Change
Malaise

CVS

DOE
Palpitations
Ankle / Foot Swelling

Pulm

Cough / Sputum

GI

Trouble Swallowing
Abdominal Pain
Nausea / Vomiting
Constipation / Diarrhea
Bowel Incontinence

GU

Recent UTI
Burning / Frequency
Bladder Incontinence

Musc

Stiffness
Back Pain
Muscle / Joint Pain
Cramping

Neuro

Numbness / Tingling
Falls / Unsteady Gait

Psych

Depression / Anxiety
Confusion / Memory Diff
Irritability / Impulsive

Heme

↑ Bruising / Bleeding
Anemia

Skin

Rash / Itching / Dry
Breakdown / Sores
Eyes
Blurred / Double Vision
Glasses
ENT
Cold Symptoms
Dentures/Dry Mouth
Dizziness / Vertigo
Hear Aid / Diff Hearing

ROS filled out by patient (see form 1120) Reviewed by physician. _____

ROS filled out by ancillary staff. Reviewed by physician. _____

PAST MEDICAL HISTORY:

Anemia DVT - RLE / LLE
Angina ESRD
Arthritis Fracture - _____
Atrial Fib GERD
CAD GI Bleed - Up / Low
Cancer Hypercholesterolemia
Cellulitis Hypertension
CHF MI - _____
COPD Osteoporosis
CVA / TIA Pneumonia
Depression PVD
DM - I / II Renal Insufficiency

S/P AKA R/L/Bi
S/P Appendectomy
S/P BKA R/L/Bi
S/P CABG
S/P Cholecystectomy
S/P Colon Resection
S/P ORIF _____
S/P Pacemaker Insertion
S/P THR R/L/Bi
S/P TKR R/L/Bi

CURRENT MEDICATIONS:

Name, Dose, Sig	Name, Dose, Sig
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES: NKDA

SOCIAL HISTORY:

Lives: With Spouse With Son / Daughter Alone _____
In Assisted Living Facility In Nursing Home
____ Level House Apartment Townhouse Mobile Home
____ Steps Ramp R / L / Bilateral Rails Elevator

Denies ETOH Admits ETOH - socially / daily Stopped ETOH
Denies Tobacco Admits Tobacco - _____ ppd x _____ years
Stopped Tobacco - _____ years ago

FAMILY HISTORY: Not Significant for: _____

Family Member History Of: _____

PFSH filled out by patient (see form 1120) Reviewed by physician. _____

PFSH filled out by ancillary staff. Reviewed by physician. _____

*History Obtained From: Patient / Family / Caregiver / _____