



A well-structured physical therapy evaluation is the foundation of effective treatment. By conducting a thorough assessment, PTs can accurately diagnose conditions, establish baselines, and create personalized treatment plans that drive better patient outcomes. A clear, organized evaluation not only enhances clinical decision-making but also ensures compliance with documentation standards and improves communication between providers. In this blog post, we'll break down the key components of a physical therapy evaluation and provide an example evaluation to illustrate the importance of clear and thorough reporting for skilled physical therapy services. We will also give an overview of how Empower EMR's software simplifies, optimizes, and speeds up physical therapy evaluations while helping physical therapy evaluation is crucial for accurate diagnosis, effective treatment, and compliance with documentation standards. Key components of an evaluation include patient history, clinical examination, functional limitation assessment, and a tailored treatment plan. Creating clear and thorough reports relies on standardization, clarity, regular audits, and the adoption of advanced technology. Empower EMR's software enhances evaluation recording through automated data entry, real-time compliance checks, and streamlined workflows. What Is a Physical Therapy Evaluation? A physical therapist assesses a patient's physical condition, functional capabilities, and limitations. This evaluation is used to diagnose the patient's issues, which in turn informs the treatment plan.What Makes This Evaluation So Important?The physical therapy evaluation is critical to creating the clinical documentation that protocols and regulatory standards and ensures the therapist is on the right path to guide the patient to the best recovery possible. This evaluation isn't just the therapist's clinical observations—it also integrates feedback and input from the patient's goals. It also constitutes an official record that is part of the patient's medical file. Key Elements of a Physical Therapy Evaluation A physical therapy evaluation consists of several key elements that contribute to constructing a comprehensive understanding of the patient's medical history, including previous injuries, surgeries, and existing health conditions. This subjective data also collects the patient's perspective, capturing their experiences, pain levels, and personal goals that help the therapist understand the patient's perspective. therapists get hands-on. They conduct a physical examination to gather objective data on the range of motion, strength, posture, and neurological function using standardized tests and measures. This patient examination confirms the subjective findings and provides a factual basis for diagnosis. Evaluation of Functional LimitationsNext, therapists analyze patient's functional problems. This evaluation helps define how the patient's physical limitations impact their daily life, whether it's difficulty walking, lifting, or participating in recreational activities. Clinical Analysis to arrive at a diagnosis. This might clarify the specific musculoskeletal or neuromuscular impairments at play and guide the development of an individualized treatment plan. Treatment plan with measurable goals that align with the patient's needs and desires. This collaborative approach ensures the patient feels involved in their healing journey and helps track progress over time. Documentation must be comprehensive, clear, and concise, ensuring compliance with the standards set by legal and regulatory bodies. Physical Therapy Evaluation, we will use a hypothetical example involving a patient named Tony, a 30-year-old construction worker suffering from persistent shoulder pain that has disrupted his daily activities and work performance. Patient Information about Tony: Age: 30 years oldOccupation: Construction workerMedical History: No prior surgeries, no chronic illnesses. Tony occasionally deals with seasonal allergies. Patient's Primary Complaint: Tony reports that he has been experiencing right shoulder pain for the past three months after lifting a heavy load at work. Here, we gathered this information to learn about Tony's condition and lifestyle and create an accurate diagnosis for a tailored treatment plan. Subjective FindingsIn the subjective examination, the therapist engages Tony in a conversation to elicit more personal insights regarding his pain. This portion of the evaluation includes the following key aspects: Pain Level: Tony rates his shoulder pain as a 6 out of 10 on a visual analog scale, stating it increases to an 8 during overhead lifting. Nature of Pain: He describes the pain as sharp, which radiates to his upper arm, especially with certain movements. Functional Limitations: David expresses a desire to return to full duties at work without pain and to resume recreational activities, such as playing basketball with friends.Understanding Tony's lived experience can determine the evaluation complexity and help tailor the subsequent treatment plan to better align with his goals.Objective FindingsNext, the therapist conducts thorough, objective tests to gather data regarding Tony's condition:Range of Motion (ROM) Assessment: Active ROM: Forward flexion is limited to 120 degrees (normal is 180 degrees). Abduction is limited to 90 degrees (normal is 180 degrees). Internal and external rotation, indicating weakness compared to the left shoulder.Special Tests: Positive Hawkins-Kennedy test, indicating possible shoulder impingement. The apprehension test shows mild discomfort but is mostly negative. Posturel Assessment: Examination reveals rounded shoulders and a forward head posture, which can contribute to shoulder dysfunction. This objective data corroborates Tony's subjective complaints and provides clinical reasoning for understanding the severity and nature of his shoulder impingement conducts a clinical analysis to reach a preliminary diagnosis of the patient's primary complaint: Diagnosis: Right shoulder impingement syndrome, likely exacerbated by postural issues and overuse in a physically demanding occupation. Contributing Factors: Poor posture and muscular imbalances appear to be contributing to functional limitations and their root causes.Treatment Plan and GoalsWith a diagnosis in hand, the therapist collaborates with Tony to formulate a treatment plan that reflects his needs, preferences, and goals:Treatment Plan:Pain Management: Soft tissue mobilization, joint mobilizati Strengthening exercises to improve scapular stability and address forward head posture. Range of Motion & Strengthening: A progressive exercises to restore function. Functional Training: Work-specific movement drills, and mobility exercises to restore function. mechanics and overhead reaching. Patient Education: Ergonomic advice and home exercise program to reinforce therapy progress and prevent recurrence. Short-term Goals (one to two weeks): Reduce pain levels to 4 out of 10 during activity. Improve shoulder range of motion by 15 degrees in flexion and abduction. Long-term Goals (four to six weeks):Achieve full, pain-free, active and passive range of motion in the right shoulder. Enable David to return to work duties without restrictions and resume basketball activities. Documentation SummaryFinally, the therapist compiles all this information into a clear and comprehensive. evaluation report:Patient Information: Documenting demographics and referral sources.Subjective/Objective/Objective/Findings: Clearly stating the patient's own words, results from physical assessments, and any relevant test outcomes.Diagnosis: Summarizing the clinical analysis.Treatment Plan: Including specific goals, modalities, exercise programs, and education topics.Best Practices for Creating Clear, Thorough Evaluation ReportsNow that we have looked at an example, let's discuss best practices for creating effective evaluation reports. Standardization and ConsistencyStandardization and ConsistencyStandard process and enhances the accessibility of information across records. By creating a template that includes sections for patient history, subjective and objective findings, clinical analysis, and treatment plans, therapists can save time and maintain high standards of care. Clarity and Precision in DocumentationEvery detail matters in physical therapy evaluations. It's crucial to use specific and clear language while avoiding jargon that may confuse those who are not familiar with medical terminology. For instance, instead of saying, "The patient demonstrates a 45-degree range of motion on shoulder flexion that can be improved with therapeutic exercise."Regular Audits and UpdatesRegular Audits safeguard the quality of clinical documentation. Periodically review evaluation reports to identify any areas for improvement in clarity, detail, and compliance with legal requirements. These audits can reveal patterns that highlight recurrent issues, such as the need for more detail in certain sections or a lack of consistency in terminology. Leveraging Technology for Quality ImprovementUsing software tools can greatly enhance the quality and efficiency of documentation software can streamline the recording process with features such as automated data entry, customizable templates, and built-in compliance checking, reducing the time therapists spend on paperwork. How Empower EMR's documentation software Enhances Evaluation data, empowering therapists to focus more on patient interaction and less on paperwork. Here's how: Automated Data Entry and Template CustomizationEmpower EMR offers physical therapists customizable templates that facilitate automatic data entry. These templates make it easier to gather and document relevant patient information without overwhelming the user. Real-Time Compliance and Error CheckingThe platform prioritizes compliance by offering built-in error checking and real-time feedback during the documentation process. This feature ensures that therapists can guickly identify any discrepancies or missing data, dramatically reducing the evaluation process. through its intuitive interface and user-friendly navigation. This enhanced workflow accelerates the documentation process and allows therapists to spend more time with their patients, which ultimately leads to better patients, which enables physical therapy practices to analyze outcomes, track patient progress, and identify trends over time. By harnessing these insights, therapists can refine their treatment strategies and provide highly skilled therapy services to ensure that patients receive the most effective care possible. The Bottom Line: Streamline Your PT Evaluations With Empower EMRPerforming a comprehensive physical therapy evaluation is key to identifying the source of a patient's condition, creating a personalized treatment plan, and communicating effectively with other members of the patient's condition, creating a personalized treatment plan, and communicating effectively with other members of the patient's healthcare team. By understanding the vital elements of an evaluation and adhering to best practices, therapists can enhance both their documentation efforts and patient care experience. Empower EMR software can be a powerful tool for therapists trying to increase the accuracy of their evaluation processes. With automated data entry, real-time compliance checks, and streamlined workflows, they can focus on what truly matters—delivering exceptional care to their patients! If you're ready to discover how Empower EMR can transform your practice, book a demo today. A Physical Therapy Initial Evaluation is a comprehensive assessment conducted by physical therapists at the beginning of a patient's treatment journey. This evaluation is crucial for establishing a baseline of the patient's physical condition including strength, mobility, and pain levels. It involves a detailed review of the patient's medical history, physical therapy examination, and the creation of a personalized treatment plan. The goal is to gather all necessary information to guide the therapy examination, and the creation of a personalized treatment plan. to view on YouTubeDuring the initial physical therapy appointment, the therapist conducts a thorough evaluation, which includes discussing the patient's medical history and the reasons for seeking therapy. The physical attributes. This examination may involve manual muscle testing, gait analysis, and special tests designed to diagnose specific conditions. The therapist and patient will also discuss symptoms, pain levels, and the patient's functional goals. This appointment sets the foundation for the patient's functional goals. the initial evaluation is critical for creating an effective treatment plan. Essential elements to document include: Patient history: Comprehensive medical history review, current medications, and the primary reason for the physical therapy referral. Clinical examination findings: Details of physical assessments performed, including muscle function tests assessments, and any observed abnormalities. Patient's goals: Documentation of the patient's personal rehabilitation goals and expected outcomes from therapy. Proposed treatments), and frequency of therap sessions. The initial evaluation in physical therapy is a crucial step in the therapeutic process, offering several key benefits that set the stage for effective treatment and recovery. Here are some of the most significant advantages: Comprehensive understanding of patient needs The initial evaluation provides physical therapists with a detailed understanding of the patient's physical condition, past medical history and, and personal rehabilitation goals. This comprehensive insight is critical for designing a treatment plan tailored to the individual's needs and challenges, ensuring a more targeted and effective therapeutic approach. Establishing a baseline for progressThis evaluation is a baseline measurement of the patient's physical abilities and limitations at the start of therapy. It enables therapists and patients to track progress over time, adjusting the treatment plan to continue meeting the patient's evolving needs and ensuring that recovery goals are effectively pursued. Enhancing patient-therapist communication The initial evaluation session is an opportunity for patients to express their concerns, symptoms, and expectations regarding physical therapy. This open dialogue fosters a strong therapeutic alliance between the patient and therapist, enhancing mutual understanding and cooperation throughout treatment. Identifying potential health issues earlyEarly detections regarding physical therapy. of potential health issues or complications is another critical benefit of the initial evaluation. By thoroughly assessing the patient's condition from the outset, physical therapists can identify and address any underlying or co-occurring health problems that may impact the patient's recovery, ensuring a holistic approach to care. Setting realistic goals and expectationsThe evaluation process allows therapists to work with patients to set realistic, achievable goals for the treatment journey, helping to manage expectations and measure success in a meaningful way. Facilitating personalized carePerhaps the most significant benefit of the initial evaluation is the ability to provide personalized care. Understanding the unique aspects of each patient's condition and lifestyle enables therapists to customize every aspect of the treatment, from selecting specific exercises and therapeutic modalities to the frequency and duration of therapy sessions. The initial evaluation in physical therapy is foundational, offering essential insights and opportunities that contribute to a successful treatment outcome. It ensures that care is patient-centered, goal-oriented, and adaptive to the individual's changing needs throughout their rehabilitation journey. Preparing for a physical therapy evaluation is crucial in ensuring that the initial appointment is as informative and effective as possible. This preparation helps create a conducive environment for the physical therapists and the patient, facilitating a comprehensive assessment that will guide the subsequent treatment plan. For physical therapists and the patient, facilitating a comprehensive assessment that will guide the subsequent treatment plan. For physical therapists and the patient plan. For physical therapist plan. For physical therapis arrive, thoroughly review their medical records and any referral notes. This helps understand the patient's medical history and any concerns that must be addressed. Prepare the evaluation space: Ensure that the evaluation space is organized and equipped with all necessary tools and equipment for conducting physical assessments, such as goniometers, resistance bands, and balance tools.Set clear objectives: Plan what needs to be accomplished during the evaluation, including specific assessment forms: Prepare and organize any forms or documentation needed for the evaluation, including intake forms, consent forms, and evaluation templates. For patients Here are detailed steps that patients can take before the evaluation and past treatment records. This information will be vital for the therapist to tailor the evaluation and treatment plan to your specific needs.Wear appropriate clothing: Dress in comfortable, loose-fitting clothing that allows for unrestricted movement. This is important as the therapist may need to assess joint mobility and muscle function. Prepare questions and goals: Think about what you wish to achieve through physical therapy and any questions about the treatment process. Being clear about your goals and concerns can greatly enhance the effectiveness of the evaluation and subsequent treatments. Arrive early for your appointment to complete any necessary paperwork without rushing, ensuring a smooth start to the evaluation process. By following these steps, physical therapists and patients can ensure that the initial evaluation is thorough and productive and lays a solid foundation for a successful therapeutic relationship and treatment outcome. A PT examination involves a patient's physical testing and assessment to understand their condition. At the same time, an evaluation analyzes the physical examination and findings to diagnose and devise a treatment plan. An initial evaluation in physical therapy is the first comprehensive assessment of a patient's condition through tests and observations. Evaluation is interpreting assessment data to make clinical patient care decisions. Physical therapy documentation is an important tool for recording therapy treatments and tracking a patient's progress. It can also be the cause of major headaches, rushed lunch hours, and excessive typing throughout the day. Students and therapists alike have experienced difficulty locating helpful physical therapy documentation examples. I know because I, too, looked in vain for defensible documentation examples and strategies on strategies on the strategies on this blog. You may not have the time to read dozens of documentation examples, so I have included below an example of 4 types of notes commonly used in physical therapy. These examples, so I have included below an example of 4 types of notes commonly used in physical therapy. similar wording for the subjective, objective, and assessment goals in other settings (such as neuro, home health, skilled nursing, or acute rehab). You can download these examples in PDF format here (click on image). Evaluation Date: 01/06/2016 Treatment Time: 09:00 to 10:00 Patient Name: Henry Smith DOB: 3/22/1957 Physician: Dr. James Anderson Medical Diagnosis: M17.12 Left knee OA s/p TKA 12/28/15 PT treatment diagnosis: R26.9 Unspecified abnormalities of gait and mobility The patient reports having knee pain for years before he consulted with an ortho surgeon in August of 2015. An X-ray revealed severe arthritis and the patient elected to undergo total knee replacement in December of 2015. The patient lives with family who are able to assist driving him to appointments until cleared by a physician to drive. The patient's goals are to return to work as a supervisor at the local car manufacturer, and to "walk without a walker or cane as soon as possible." Past Medical History: Patient is married and lives in a 2-story home with 4 steps to enter and 13 stairs to the basement and upstairs. Master bedroom/bathroom is on the main floor. CC: Increased pain and stiffness in left knee prevents him from sleeping well at night and limits his ability to walk or stand for more than 10 minutes. Precautions: WBAT with FWW, progressing to cane as tolerated Barriers to Learning: none Home Barriers: 4 steps to enter home Prior Functional Level: Patient was independent in all areas. Patient stands a day, navigating stairs throughout the facility. Cognition: AOx3 Vital Signs: BP 122/88, HR 76, RR: 16 Posture: Patient stands with forward flexed trunk position using walker and demonstrates a favoring of the left knee in keeping it flexed. Patient denies tenderness behind the knee and along the increases with knee flexion, described as "tightness" due to increased swelling. Patient rates pain at 4/10 at present, 3/10 at best and 6/10 at worst. Patient reports decreased sensation along the incision noted along midline of left knee. Steri strips are present along a 20 cm incision. Skin appears dark pink, dry and well healing. No open areas noted. Mild to moderate edema noted at knee with pitting noted as 1+ at tibia. No signs of infection noted. Lower Extremity Functional Outcome Score: 55% disability score ROM / Strength * = painMMT RMMT LA/PROM (R)A/PROM (R)A Extension5/54/51010Hip Abduction5/54/5WNLWNLAnkle Dorsif1.5/55/5WNLWNLAnkle Plantar.5/54/5WNLWNLAnkle decreased hip extension with push off and impaired ability to turn corners due to unsteadiness attributed to unnatural use of walker. Advised patient on safe use of walker to encourage proximity to device. Balance: Rhomberg stance: unable on Left, for up to 3 seconds on Right. Tandem stance: requires UE support with balance loss upon perturbation. Reflexes: DTR intact at ankle; not tested at knee due to incision at knee. Extensibility: Tightness noted in the following muscle groups: bilateral hamstring, quadriceps, and gastroc/soleus. Special Tests: PDVT Screen: negative. Treatment Provided: Total knee protocol to include instruction of HEP and performance of the following exercises: ankle pumps x 20, quad sets x 15, SLR x 10, sidelying SLR x 10, heel slides x 15. Cold pack x 15. Cold bearing activities, altered posture, lack of home exercise program, impaired gait form and use of assistive device. Assessment Statement: Patient presents with signs and symptoms consistent with diagnosis of L knee OA, s/p 1 week post operative L TKA. Rehab potential is excellent. Key impairments include: decreased ROM and strength of the left lower extremity, poor balance and compensatory gait patterning, increased swelling, and pain with functional activities such as squatting, walking, and stairs. A skilled PT is required to address these key impairments and to provide and progress with an appropriate home exercise program. This evaluation is of moderate complexity due to the changing nature of the patient's presentation as well as the comorbidities and medical factors included in this evaluation. Short Term Goals Within 2 weeks, the patient will achieve 90° knee flexion consistently in order to progress with functional activities such as rising from a chair with equal weight bearing. Within 2 weeks, the patient will demonstrate improved quad strength and motor control as noted by ability to perform SLR without lag in order to progress into advanced ther ex. Within 2 weeks, the patient will demonstrate independent ambulation on level surfaces without a straight cane in order to safely navigate the community without gait compensation. Within 5 weeks, the patient will demonstrate an increase in quadriceps strength by 1 MMT grade to ascend and descend stairs without the knee buckling. Within 6 weeks, the patient will demonstrate increased knee flexion AROM to 120 in order to improve the patient's ability to descend 2 flights of stairs at work. Within 6 weeks, the patient will be seen by a PT and/or PTA 2x per week for 6 weeks under the diagnosis of Left knee OA in order to improve the patient will be seen by a PT and/or PTA 2x per week for 6 weeks, the patient will be seen by a PT and/or PTA 2x per week for 6 weeks under the diagnosis of Left knee OA in order to improve the patient will be seen by a PT and/or PTA 2x per week for 6 weeks. s/p L TKA and will be reassessed every 7-10 visits for progress. Treatment to Include: AROM/AAROM/PROM, balance and proprioception training, neuromuscular re-education, and ice pack to LLE. Certification period: 1/6/16 - 2/24/16 The patient has been educated in the evaluation findings, prognosis, and plan of care, and is in agreement and willing to participate in therapy. Thank you for this referral and please call xxx-xxxx with any questions or concerns. Physical Therapist: Date: Time: Physician Signature: CodeProcedureUnit / Time97162PT Evaluation (Moderate)1 / 25 minutes97110Therapeutic Exercise2 / 25 minutes97010Cold Pack (untimed)1 / 10 minutesTotal Treatment Time60 minutes50 minutes Total Treatment Time60 minutes50 minutes5 Anderson Medical Diagnosis: M17.12 Left knee OA s/p TKA 12/28/15 PT treatment diagnosis: R26.9 Unspecified abnormalities of gait and mobility Patient stated "I am better able to sleep at night with less throbbing in my knee. Today my pain level is 3/10." Patient used FWW to ambulate into clinic with equal step length noted. 20 minutes Therapeutic Exercise (97110): Supine exercises included: active quad sets x 15, SLR x 15, Hamstring curl x 10 with ankle dorsiflexion x 3 each rep, SAQ with bolster x 15, PROM flexion to 95 degrees. Standing: mini squats x 10, hip abduction x 10 bilaterally, step up to 3" step x 10 alternating LE. 10 minutes Neuromuscular Re-education (97112): Weight shifting on balance pad 3×20 seconds, Rhomberg stance on pad 3×20 seconds with one UE support, semi tandem stance with perturbations from therapist 2×1 min., rocker board for proprioceptive training x 3 min. 10 minutes Manual Therapy (97140): Seated tibiofemoral distraction grade 2 mobilization for pain relief, supine patellar mobilizations in superior/inferior direction: grade 2 x 4 minutes, mobilization with knee supported by bolster for comfort following exercises and treatment. Instructed patient to continue using ice intermittently at home with elevation throughout the day to minimize swelling. The patient demonstrates lack of quad muscle recruitment in order to achieve greater knee extension. Instructed patient in co-contraction of quads to improve motor recruitment in co-contraction of quads to improve motor recruitment during knee extension. CPT CodeProcedureUnit / Time97110Therapeutic Exercise1 / 20 minutes97112Neuromuscular Re-ed1 / 10 minutes97140Manual use of FWW recommended. Progress patient with strengthening exercises to increase quad activation and trial straight cane at parallel bars. Therapist Signature: Date: Time: Therapy1 / 10 minutes97010Cold Pack1 / 10 minutesTotal Treatment Time50 minutesTotal Treatment Time50 minutesTotal Timed Minutes40 minutes Total Timed Minutes40 minutes Total Treatment Time 10:00 to 1/27/16 Start of Care: 1/6/16 Patient Name: Henry Smith DOB: 3/22/1957 Physician: Dr. James Anderson Medical Diagnosis: M17.12 Left knee OA s/p TKA 12/28/15 PT treatment diagnosis: R26.9 Unspecified abnormalities of gait and mobility Pain/Location: 2/10; Patient states, "My knee pain has decreased significantly, allowing me to sleep through the night and to sit to rest. Attendance: Number of Treatments: 7; Cancellations: 0; No Shows: 0 Treatment Included: Ther ex, neuromuscular re-ed, manual therapy, cold pack, HEP SLR lag: 1 degree, Rhomberg test: negative; sensation: intact; incision: closed, clean, and healing well. Patient uses a straight cane for ambulation. (Examples for treatment provided would follow a similar format as noted above in the Daily Note Example. You may also document treatment provided in a flow sheet. To shorten this example, the treatment listed in the Sample Daily Note.) * = painMMT RMMT LA/PROM (L)Knee Flexion5/54+/5125/125100 / 110 Knee Extension5/54/50 / 0 -2 / - 2 *Hip Flexion5/54+/5120120Hip Extension5/54+/51010Hip Abduction5/54+/5WNLWNLAnkle Dorsif1.5/55/5WNLWNLAnkle Plantar.5/54+/5WNLWNLAnkle Plantar.5/54+/5WNLWNLAnkle Plantar.5/54+/5WNLWNLAnkle Dorsif1.5/55/5WNLWNLAnkle Plantar.5/54+/5WNLWNLAnkle Plantar.5/54+/5WNLWNLAnkle Dorsif1.5/55/5WNLWNLAnkle Plantar.5/54+/5WNLWNLAnkle Plantar.5/54+/5WNLWNLANKL Patient lacks full strength to ascend full flight of stairs reciprocally and demonstrates impaired balance on dynamic surfaces. Please sign and fax to: CPT CodeProcedureUnit / Time97110Therapeutic Exercise1 / 20 minutes97112Neuromuscular Re-ed1 / 20 minutes97140Manual Therapy1 / 10 minutes97010Cold Pack1 / 10 minutesTotal Treatment Time60 minutesTotal Timed Minutes Date Time: minutes Treatment Date: 02/17/2016 Treatment Time: 10:00 to 10:50 Time Period: 01/27/16 to 02/17/16 Start of Care: 1/6/16 Patient Name: Henry Smith DOB: 3/22/1957 Physician: Dr. James Anderson Medical Diagnosis: M17.12 Left knee OA s/p TKA 12/28/15 PT treatment diagnosis: R26.9 Unspecified abnormalities of gait and mobility Pain/Location: 0/10; Patient states, "I no longer need to use the cane and have been able to navigate up and down my steps 8 times a day. My LE swells when I stand more than 3 hours at a time, but resting for 20 minutes allows me to stand throughout the day. I plan to return to work March 7th following my visit with the surgeon on 3/4/16.' Attendance: Number of Treatments: 13; Cancellations: 0; No Shows: 0 Treatment Included: Ther ex, neuromuscular re-ed, manual therapy, cold pack, HEP Rhomberg test: negative; sensation: intact; incision: closed, clean, and healing well. LEFS: 10% perceived impairment. No assistive device used. (Examples for treatment provided would follow a clean, and healing well. LEFS: 10% perceived impairment. No assistive device used. (Examples for treatment provided would follow a clean, and healing well. LEFS: 10% perceived impairment. No assistive device used. (Examples for treatment provided would follow a clean, and healing well. LEFS: 10% perceived impairment. No assistive device used. (Examples for treatment provided would follow a clean, and healing well. LEFS: 10% perceived impairment. No assistive device used. (Examples for treatment provided would follow a clean, and healing well. LEFS: 10% perceived impairment. No assistive device used. 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LEF Extension5/55/50 / 0 0 / OHip Flexion5/55/5120120Hip Extension5/55/51010Hip Abduction5/55/51010Hip Abduction5/55/5WNLWNLAnkle Dorsifl.5/55/5WNLWNLAnkle Dorsifl.5/55/5WNLWNLAnkle Plantar.5/55/5WNLWNLAnkle Plantar.5/55/5WNLWNLE Plantar.5/55/5WNLWNLANKLE Plantar.5/55/5WNLWNLANKLE Plantar.5/55/5WNLWNLANKLE Plantar.5/55/5WNLWNLANKLE Plantar.5/55/5WNLWNLE Plantar.5/55/5WNLWNLE Plantar.5/55/5WNLWNLE Plantar.5/55/5WNLWNLE Plantar.5/55/5WNLWNLE Plantar.5/55/5WNLW CPT CodeProcedureUnit / Time97110Therapeutic Exercise1 / 15 independent with advanced HEP and is agreeable to discharge with all goals met. x Discharge from PT with all goals met. Therapist Signature: Date: Time: Physician Signature: Date: Time: minutes97112Neuromuscular Re-ed1 / 15 minutes97530Therapeutic Activity1 / 20 minutesTotal Treatment Time50 minutesTotal Timed Minutes50 minutes Get in the habit of starting your sentences with action words that describe the patient's ability to perform functional tasks. Here are a few keywords to consider: "The patient... performs demonstrates, reaches, achieves/does not achieve, lacks, displays "A functional movement... poor foot gerformance... poor foot foot gerformance... poor foot gerformance... clearance, improper hip alignment, impaired posture, increased stress, further irritation. "Reason for Therapy to continue...." or "Key impairments to be addressed with further therapy in order to ... to progress with stability training, to decrease the risk of falling, to safely manage lifting # items at home, to independently don/doff clothing, to perform head checks in vehicle safely, etc." It's not enough to simply say, "The patient performed the exercises with good form." That doesn't tell us anything, and it neglects to mention, what did you do?? Most of the difficulty in writing defensible documentation lies in the assessment section. By the time you get to this section, you might feel as if you've used all your mental energy typing the preceding subjective and objective sections! With my 60+ examples of assessment phrases in real-life scenarios, you'll have access to a comprehensive resource that will improve the efficiency and quality of your writing. These Therapy Documentation Templates will help you effortlessly write physical therapy assessment phrases that are as skilled treatment. Make sure your documentation shows it - but in less time and with better clarity! Because Physical Therapists deserve to go home to family, not paperwork. ResourcesPhysical Therapy Evaluation Example Download nowIf you're looking for a physical therapy (PT) evaluations with new patients or clients, you're in the right place. This article includes information on how to complete physical therapy evaluations, along with physical therapy assessment documentation examples and a free downloadable physical therapists complete during the initial PT visit. Physical therapists perform patient evaluations in order to gather enough information to make an accurate diagnosis, develop a treatment plan, and build accurate and attainable goals for the patient. The examination consists of a complete subjective and objective examination, followed by an assessment, and, then, a treatment plan. The PT evaluation is a formal, thorough document which will be a part of the patient's official medical record. All parties involved—including the referring doctor, patient, insurance companies, and attorneys—-are permitted access (with specific permissions/patient consists of the patient history, systems review, and objective data collection. After the examination is completed, physical therapists will complete a clinical assessment. Another way to record this information is by using a SOAP note template. A thriving practice starts herePrior to the first galance at the patient's case prior to the visit That said, the patient intake will serve as a guide to the evaluation. The patient intake typically includes: Patient demographics are distory of symptoms, aggs, eases History of symptoms, aggs, eases History of symptoms are distory. very intentional about the patient. The physical therapist should maintain control and direct the communication to ensure the interview stays focused. Subjective examination During this part of the evaluation, physical therapists will review all of the patient. that the PT will delve into in more detail include: Chief complaintMechanism of injuryPrevious level of functionCurrent level of function Aggs/easesSeverity/pain scale NatureNeurological symptomsReview of imaging and physician reports The free, downloadable physical therapy evaluation example template, which you can print or save to your electronic health record (EHR), includes sections to collect and record this information. The objective portion of the examination is the quantitative portion of the examination is the information. These measurements include:Active and passive range of motion Manual muscle testingNon-physiological joint motionSensory and neurological testing Static postural analysisFunctional movement assessment Special clinical tests and measures The assessment portion of the evaluation is focused on analyzing the information gathered during both the subjective and objective portions of the examination. The goal is to create a succinct assessment of the patient's PT needs, treatment, plan of care, and diagnosis. First, evaluate and synthesize the data from the examination, and ascertain if it is within the physical therapy scope of practice. Then, the next steps in the assessment portion include: Establish a diagnosis During the assessment, the physical therapists will determine what specific ICD-10 code(s) to be used to classify the patient. Design a customized plan of care Next, physical therapists will determine what specific ICD-10 code(s) to be used to classify the patient. Design a customized plan of care Next, physical therapists will determine what specific ICD-10 code(s) to be used to classify the patient. Design a customized plan of care Next, physical therapists will determine what specific ICD-10 code(s) to be used to classify the patient. Design a customized plan of care Next, physical therapists will determine what specific ICD-10 code(s) to be used to classify the patient. Design a customized plan of care Next, physical therapists will determine what specific ICD-10 code(s) to be used to classify the patient. Design a customized plan of care Next, physical therapists will determine what specific ICD-10 code(s) to be used to classify the patient. Design a customized plan of care Next, physical therapists will determine what specific ICD-10 code(s) to be used to classify the patient. Design a customized plan of care Next, physical therapists will determine what specific ICD-10 code(s) to be used to classify the patient. Design a customized plan of care Next, physical therapists will determine what specific ICD-10 code(s) to be used to classify the patient. Design a customized plan of care Next, physical therapists will determine what specific ICD-10 code(s) to be used to classify the patient. Design a customized plan of care Next, physical therapists will determine what specific ICD-10 code(s) to be used to classify the patient. Design a customized plan of care Next, physical therapists will determine what specific ICD-10 code(s) to be used to classify the patient. Design a customized plan of care Next, physical therapists will determine what specific ICD-10 code(s) to be used to classify the patient. Design a customized plan of care Next, physical therapi plan of care is the overall plan that will be used to help reduce the patient symptoms, allow the patient to return to function, and to meet both the patient as well as the treatment frequency and duration of care (i.e., two times per week for six weeks, at which time a formal reevaluation will be performed). A thriving practice starts herePhysical therapy assessment documentation examples that may be included in the plan of care are: Treatment of soft tissue Manual therapy Neurological reeducationHome exercise programFunctional dry needlingTapingBiomechanical educationGait training Patient educationActivities of daily living The prognosis is a statement of how well the patient may do with the established plan of care. The prognosis is based on many factors, including:Past history/recurrenceChronicityComorbidities and disease processes Acuity of the chief complaintAccess to iance Patient goals Physical therapy goals are established to provide a framework for the treatment plan. The goals ensure all parties are on the same page, and that the appropriate treatments are being performed. Goals will also guide adjustments to the treatment program if they are not being achieved. The goals must be consistent, aligned with the patient's goals, and rooted in function—not pain. There are both short-term goals (for a duration of care between 4-8 weeks) and beyond). Typically, physical therapists use the SMART goals model to established (for a duration of care between 4-8 weeks) and beyond). goals.SMART stands for:Specific: Who/what/when/where/why for established goalsMeasurable: Able to track success via objective measurements throughout the duration of careAttainable in the necessary timeframe Realistic: Patients will be able to return to functionTemporal or time-bound: Able to complete within a designated amount of timeFor commercial and federal insurances, a newer requirement has been added that requires physical therapists to define the evaluation codes help define the intricacy of a specific patient case, as follows: Moderate complexity: 97162A thriving practice starts hereAfter finishing the first visit and recording all information using the physical therapy evaluation example template, it is essential for physical therapy evaluation example template for physical therapy evaluation using the physical therapy evaluation example template. current plan of care with their client. Physical therapists should remain conscious of the interaction and attuned to a patient's non-verbal cues. Being gentle with the patient regarding their diagnosis, and setting realistic expectations for the patient's non-verbal cues. process and empower the patient to have agency in their care. Once the patient visit is complete, the physical therapy assessment documentation, ensure the document is cohesive, and then make it an official part of the patient record. After sharing it with the necessary parties (with patient consent), the treatment process can begin. A formal reevaluation will take place about six weeks into the patient's treatment, where physical therapy practice from one simple, secure EMR with SimplePractice. Effectively manage scheduling, billing, documentation, and more Stay secure with a HIPAA-compliant solution you can trust Take your practice free for 30 days. No credit card required. A physical therapy evaluation is a crucial step in providing effective treatment and ensuring proper reimbursement. Whether you are a new graduate or a seasoned physical therapist, having a comprehensive evaluation template can greatly enhance your ability to provide quality care and meet documentation requirements. In this article, we will explore the key components/requirements of a comprehensive physical therapy evaluation template and provide a customizable evaluation for a patient's plan of care and is essential for effective treatment. It allows the therapist to assess the patient's condition, develop a diagnosis, set goals, and create a plan of care tailored to the individual's needs. A well-documented evaluation is crucial for reimbursement purposes, as it provides the necessary information to support the medical necessary information is captured. It serves as a quide reminding the therapist of the key components that need to be addressed during the evaluation. By using a template, therapists can ensure that their documentation is consistent and defensible. Creating a comprehensive physical therapy evaluation template can help ensure that all necessary components are addressed and documented. Here is a step-by-step guide to developing your own template: Before starting the evaluation, review relevant information such as the patient's prescriptions, demographics, past medical history, and current medications. This information such as the patient's chart using digital patient intake forms. Consider administering a patient-related outcome measure (PROM) at this stage to gather additional information, including their name, date of birth, contact information, and relevant demographic details. This section also includes space for insurance information, referral source, and any relevant consent forms. The past medical history section captures important informations. It is essential to understand the patient's medical background as it may influence their response to therapy and help identify any potential contraindications or precautions. Documenting the patient's current medications and any known allergies is crucial for ensuring safe and effects that may impact therapy sessions. During the subjective examination, gather information about the patient's chief complaints, previous level of function, mechanism of injury, employment and work history, and medical and surgical history. Use open-ended questions to encourage the patient to provide detailed information and utilize structured templates or checklists to ensure comprehensive data collection.Include the SINSS model (severity, irritability) to assess the severity and characteristics of the patient's condition. This model can help guide the therapist's clinical reasoning and treatment approach. In this section, the patient's primary reason for seeking physical therapy is documented. The therapist should encourage the patient to provide a detailed description of their symptoms, including the onset, duration, and any exacerbating or relieving factors. This information helps establish a baseline for treatment and guides the therapist in formulating appropriate goals and interventions. The mechanism of injury section records the patient's description of how their injury occurred, such as a fall, motor vehicle accident, or sports-related incident. This information helps the therapist understand the forces involved in this section, which helps establish a baseline for measuring functional progress. The patient's surgical history should be documented, including any prior surgeries or procedures related to their current condition. The therapist should inquire about the date of the surgery, type of procedures related to their current condition. identify any potential contraindications or precautions during treatment sessions. Patient states he tore his R ACL playing basketball during men's league. He came down from getting a rebound and immediately felt a pop. He was able to walk off the court but something didn't feel right. Reported some swelling that night and the next day with moderate pain and felt like his knee was going to give out on him, so he set up an appointment with Dr. Casperson who sent him for an MRI. MRI was (+) for an ACL tear. Opted to wait a few weeks for surgery due to a busy month at work and needing to plan for his recoveryPrior Functional Level: Patient was independent in all areas. Current: 6/10 Best: 6/10 Worst 8/10What makes the pain better? Patient states he takes Advil occasionally. Resting, and icing helps the most. What makes the pain worse? Standing, sitting, or standing for long periods. Collect objective data through various measures such as range of motion assessments, muscle length testing, manual muscle testing, joint accessory motion testing, and special tests. These objective measures provide quantifiable data that can be used to track progress and guide treatment decisions. Neighboring joints and systems screeningActive and passive range of motion collectionMuscle length testing; Nanual muscle testing; Nanual muscle testing; Palpation and joint accessory motion testing; Additional outcome measures can provide valuable information about the patient's functional status and help monitor changes over time. Knee Flexion: Left A/PROM: 140/143 Right A/PROM: 110/116Knee Extension: Left A/PROM: -3/-5 Right A/PROM: 5/0LMMT: Not Tested (Post Op)Special tests, including a Lachman test, McMurray test, and anterior drawer test were all positive for an ACL tear on the right side. Gait: NWB on RLE using bilateral axillary crutches with TROM brace. Posture: WB through L LE only while entering the clinicSynthesize the information gathered during the subjective examinations to develop a clear and concise assessment. Identify any impairments, functional limitations, and underlying causes of the patient's condition. Use evidence-based practice guidelines and clinical reasoning to develop a clear and concise assessment. patient's condition. Provide a prognosis that includes the patient's potential for improvement and factors that may impact their outcomes. Consider the patient, there must also include a statement of the patient's prognosis. Simply stating excellent, good, fair, or poor is no longer sufficient. Providing examples as to why you have assigned this prognosis is required. Some of these factors include:Motivation;Comorbidities and past medical history;Acuity of the injury or primary complaint; orNature of the dysfunction or related disease processes. Designate the complexity level of the evaluation using the appropriate CPT code. Consider factors such as the duration of the evaluation, history, examination, clinical presentation, and decision-making process when selecting the code. The patient underwent surgery three days ago for a right anterior cruciate ligament reconstruction (R ACLr) using a bone-patellar tendon-bone (BPTB) autograft. The procedure was performed on March 3, 2023, by Dr. Casperson.Following the surgery, the patient is experiencing a notable decrease in overall function as indicated by his Lower Extremity Functional Scale (LEFS) score. Additionally, the patient is displaying poor gait quality while ambulating into the clinic, and he is non-weight bearing (NWB) on the surgical leg. Moreover, the patient is reporting an increase in pain. It is recommended that the patient undergo skilled physical therapy (PT) to aid in his recovery and facilitate his return to his prior level of function (PLOF). Problem Summary: Increased gain at right knee, decreased ROM of right knee, decreased strength of R LE, balance deficits in standing, difficulty with weight bearing activities, altered posture, impaired gait. Potential for Rehab: Excellent Complexity: ModerateSet specific and measurable goals for the patient to achieve as a result of skilled physical therapy services. Utilize the SMART goal framework (specific, measurable, attainable, realistic, and time-bound) to ensure that the goals are meaningful and achievable. These goals should align with the patient's functional needs and desired outcomes, serving as a roadmap for their treatment plan. Align the goals with the patient's personal therapy journey and involve them in the goal-setting process. This promotes patient engagement and increases their motivation to actively participate in their treatment. Example Goals Short Term Goals By March 31, 2023, the patient should achieve full passive range of motion (PROM) in knee extension, reaching -5 degrees to match the range of motion in the left lower extremity (L LE). By March 31, 2023, the patient is targeted to enhance their knee extension Isometric Quad Set (ISOM) strength, with the objective of achieving a 4/5 score on manual muscle testing (MMT). By March 31, 2023, the patient should be able to ambulate without experiencing pain or displaying an antalgic gait while utilizing Axillary crutches. By March 31, 2023 the patient will report a 50% reduction in knee pain at night, which will facilitate their ability to fall asleep more comfortably. By April 28, 2023, the patient is expected to achieve the ability to ambulate without displaying an antalgic gait, experiencing pain, or relying on assistive devices (AD). By May 26, 2023, the patient should be able to ascend and descend stairs without any knee pain. This improvement is crucial as it will enable the patient to perform work-related tasks, such as navigating the office facility, comfortably. By May 26, 2023, the patient's goal is to attain Quadriceps Index (HI) greater than 75%. By May 26, 2023, the patient's objective is to improve their Lower Extremity Functional Scale (LEFS) score to over 40 out of 80.Develop a comprehensive plan of care that outlines the frequency and duration of therapy sessions, as well as the anticipated interventions. Include the planned interventions, such as therapeutic exercises, manual therapy, neuromuscular re-education, and therapeutic modalities. Ensure that the interventions: AROM/AAROM/PROM, balance and proprioception training, Therapeutic exercises, HEP, mobilization, posture training, Manual Therapy, Neuromuscular re-education. Download Free Template here Whether you are fresh out of PT school or you are fresh out of PT school reimbursement today. But completing a good initial evaluation is an art form. And like any craft, practicing and honing your skills is a must. To help, EMRs have long since held center stage for documentation simplicity and efficiency while ensuring behind-the-scenes regulatory checks are completed. And while less time spent on a computer to document is great, every therapist must keep in mind that their craft starts with the evaluation by way of human interaction. So, let's jump into this explainer of how to create a rock-solid eval-complete with a physical therapy evaluation and ExaminationOftentimes, the words evaluation and examination are used synonymously to the confusion of clinicians and patients alike. But don't fall prey to this pitfall. A complete PT evaluation starts with a clinical examination comprising the patient history, systems review, and objective data collection. Then, the PT communicates their findings in an evaluation followed by a prescribed plan of care (POC). Just remember that an evaluation cannot be completed without a thorough examination of the patient. Ultimately, think of a full evaluation as a very in-depth SOAP note—the subjective, assessment, and plan analyses for a patient's treatment. Let's break this down. The Evaluation Preliminary StepsBefore jumping onto your stool and interviewing your patient, take a moment to review information like their prescriptions, demographics, pain chart, past medical history, and current medications. These can be collected ahead of time—and transferred directly to the patient related outcome measure (PROM) at this stage, as well. Technically, this can be completed before, during, or after the evaluation—you'll decide what works best for your workflows. However, if you find yourself pressed for time, tracking PROMs through an application built to manage this data can give valuable insight to your patient's needs, and ultimately boost outcomes. The Subjective Examination Often overlooked, but likely the most important part of the evaluation is the subjective examination. It initiates the clinical reasoning from which you will develop your diagnosis and POC. It is so important, in fact, that Nobel Peace Prize laureate Bernard Louw has stated, "medical history provides sufficient information in about 75% of patient encounters to make the diagnosis before performing a physical examination and additional tests." Knowing where, when, and how to start interviewing your patient requires practice.

approach provides therapists with a template to accurately and efficiently collect this information. A few of the topics that should be covered during the subjective examination include, but are not limited to:Chief patient complaints; Previous level of function; Mechanism of injury (MOI); Employment and work history; Medical and surgical history; andSINSS (which stands for severity, irritability, nature, stage, and stability regarding the patient's condition).Gathering intel via the SINSS model will create a clear picture of why the patient has come to you and where you can start working toward their road to recovery.Objective Measures in a Patient ExaminationWith all the subjective examination data collected, you can now use all those skills you learned from PT school to gather the relevant information pertaining to your patient's primary complaint, as well as any related deficits that will need to be addressed going forward. These factors include: Neighboring joints and systems screening; Active and passive range of motion collection; Muscle length testing; Manual muscle testing; Neurodynamic testing; Palpation and joint accessory motion testing; Additional outcome measures; Special tests are completed toward the end of the objective data collection. This is done intentionally to remind PTs that special tests are used to confirm or rule out a diagnosis based on the other data that was collected. Reliance on special tests. AssessmentNow that all this subjective and objective data has been collected, it must be compiled into a succinct assessment of the patient's need for physical therapy, while also clearly stating the treatment diagnosis, prognosis, and goals. DiagnosisIn some instances, the diagnosis is already written on the prescription, but as many therapists know, the medical diagnosis on the prescription may not align with the treatment diagnosis. Or, perhaps the patient came to physical therapy via direct access with no prescription at all. To stay on task, focus on the treatment diagnosis representing the injury or condition that you—the therapist—are treating. This treatment diagnosis will be identified by an ICD-10 code.PrognosisWith every assessment of the patient, there must also include a statement of the patient's prognosis. Simply stating excellent, good, fair, or poor is no longer sufficient. Providing examples as to why you have assigned this prognosis is required. Some of these factors include:Motivation;Comorbidities and past medical history;Acuity of the injury or primary complaint; or Nature of the dysfunction or related disease processes. Goals for the patient to achieve as a result of skilled PT services is a required next step. For this, I recommend using SMART goals. Follow this model to ensure your patients' goals are: Specific about the who, what, where, when, and why; Measurable so that you can properly monitor progress; Attainable in a reasonable and necessary timeframe; Realistic in regards to achieving a specific function and purpose; and Time-bound in that they give limits and clear dates to measure progress. Goal setting is not a one-way street. which goals fit best into their personal therapy journey. Plan of CareFor Medicare beneficiaries receiving physical therapy, a POC is a regulatory must. For other insurers (or cash-pay practitioners) the rules differ. Regardless, the POC provides the evaluating PT a chance to describe how physical therapy is going to solve a particular patient's functional problems. The assessment has fulfilled much of the POC's requirements. What remains is to state the frequency and duration for which the patient most in achieving their goals. Evaluation Complexity The evaluation is nearly complete, but there is one final step: designating the complexity of the evaluation. Federal and commercial payers started requiring more specific CPT codes for evaluations in 2017 to better quantify and reflect the complexity of patients' injuries, and thus their prescribed treatment. There are three CPT codes that define complexities as low (97161), moderate (97162), or high (97163). To assist you in choosing the right code for a given case, five categories are used to qualify each level of complexity: Duration; History; Examination; Clinical presentation; and Decision making. For more insight on this topic, check out our one-page guide on how to select the right complexity for your evaluations. So we have covered the basics of a good physical therapy evaluation, but for any visual learners out there, here is an example of one. For simplicity's sake, we kept it in a standard SOAP format. SubjectiveMichael comes to therapy reporting a sudden onset of calf pain following the recent "Dunder Mifflin Scranton Meredith Palmer Memorial Celebrity Rabies Awareness Pro-Am Fun Run Race for the Cure." He states that after starting out too fast, he felt a sudden pulling and cramping sensation deep within the calf muscle and had to walk the rest of the race. Using a SINSS model, the evaluating therapist concludes the following: Severity: using the visual analog scale (VAS), pain is rated a 3/10 presently, 6/10 at worst, and 1/10 at best.Irritability: pain is worse with climbing stairs, stretching the calf, sitting to a low surface, and running. Pain is alleviated with rest, ice, and massage.Nature: there do not appear to be any red or yellow flags, pain appears mechanical in nature.Stage: the injury occurred two weeks ago, and is in the late acute stage of healing.Stability: the patient states they are improving Michael's past medical history is significant for a right foot burn two years ago (on a George Foreman grill), anxiety, and hypertension. He has completed an outcome measure via his digital intake forms and scored a 68/80 on the Lower Extremity Functional Scale (LEFS). Objective Tests and MeasuresThe following deficits were found in Michael's examination: Assessment Michael presents with pain and stiffness following an acute strain to the medial gastrocnemius muscle suffered two weeks ago with deficits in range of motion and strength in the lower limb as well as an abnormal gait pattern, and intolerance to functional activities of running, stairs, and sitting to low surfaces. He would benefit from skilled physical therapy services to address these impairments and restore normal ROM and strength in the lower limb while reducing pain and improving activity participation. Due to his motivation to run again and return to a pain-free prior level of function, Michael has a good prognosis. Michael's goals are as follows: Improve active and passive ROM into dorsiflexion to at least 15 degrees in order to ambulate with a normalized heel strike at initial contact in three weeks. In three weeks in order to ambulate with a normalized heel strike at initial contact in three weeks. In three weeks is one complain of pain when ascending steps over the course of an eight-hour work day. Improve calf strength to perform 25 unilateral heel raises on the involved side for improved ability to propel himself when running and negotiating steps by six weeks. Improve the LEFS by at least 9 points to match the minimal clinically important difference for return to normal function by six weeks. Plan of CareTo meet these goals, Michael would benefit most from skilled therapy to be received twice a week for six weeks. Skilled PT interventions will consist of: Therapeutic exercise (97110); Therapeutic activity (97530); Neuromuscular re-education (97116); Therapeutic modalities using cryotherapy and thermotherapy PRN (97010); and Unattended electrical stimulation for pain control PRN (G0283).ComplexityLow complexity evaluation (97161) due to a 20-minute duration, a past medical history without any personal factors and/or comorbidities that could impact the POC, examination of body systems completed on one to two elements, the patient presents with a stable condition, and clinical decision making using the LEFS was of low complexity.Well, there you have it. The what, how, when, why, and practically every other question in between answered on how to craft a comprehensive and defensible physical therapy evaluation. Have any additional evaluation tips, tricks, or just a simple question? Drop us a line in the comment section below and our team will do their best to answer them.