

DOCUMENTATION TEMPLATE FOR PHYSICAL THERAPIST PATIENT/CLIENT MANAGEMENT

Outpatient Form 1, Page 1

Today's Date: _____
Patient ID#: _____

1 Name:

a Last: _____
b First: _____ c MI: _____ d Jr/Sr: _____

2 Street Address: _____

City: _____ State: _____ Zip: _____

3 Date of Birth: Month Day Year

4 Sex: a Male b Female

5 Are you: a Right-handed b Left-handed

6 Type of Insurance: a Insurer: _____
 b Workers' Comp c Medicare d Self-pay e Other

7 Race:

- a American Indian or Alaska Native
- b Asian
- c Black or African American
- d Hispanic or Latino
- e Native Hawaiian or Other Pacific Islander
- f White

8 Ethnicity:

- a Hispanic or Latino
- b Not Hispanic or Latino

9 Language:

- a English understood
- b Interpreter needed
- c Language you speak most often: _____

10 Education:

- a Highest grade completed (Circle one): 1 2 3 4 5 6 7 8 9 10 11 12
- b Some college / technical school
- c College graduate
- d Graduate school / advanced degree

SOCIAL HISTORY

11 Cultural/Religious: Any customs or religious beliefs or wishes that might affect care? _____

12 With whom do you live:

- a Alone
- b Spouse only
- c Spouse and other(s)
- d Child (not spouse)
- e Other relative(s) (not spouse or children)
- f Group setting
- g Personal care attendant
- h Other: _____

13 Have you completed an advance directive? a Yes b No

14 Who referred you to the physical therapist: _____

15 Employment/Work (Job/School/Play)

- a Working full-time outside of home
- b Working part-time outside of home
- c Working full-time from home
- d Working part-time from home
- e Homemaker
- f Student
- g Retired
- h Unemployed
- i Occupation: _____

LIVING ENVIRONMENT

16 Does your home have:

- a Stairs, no railing
- b Stairs, railing
- c Ramps
- d Elevator
- e Uneven terrain
- f Assistive devices (eg, bathroom): _____
- g Any obstacles: _____

17 Do you use:

- a Cane
- b Walker or rollator
- c Manual wheelchair
- d Motorized wheelchair
- e Glasses, hearing aids
- f Other: _____

18 Where do you live:

- a Private home
- b Private apartment
- c Rented room
- d Board and care / assisted living / group home
- e Homeless (with or without shelter)
- f Long-term care facility (nursing home)
- g Hospice
- h Other: _____

19 GENERAL HEALTH STATUS

- a Please rate your health: (1) Excellent (2) Good (3) Fair (4) Poor
- b Have you had any major life changes during past year? (eg, new baby, job change, death of a family member) (1) Yes (2) No

20 SOCIAL/HEALTH HABITS

- a Smoking:
 - (1) Currently smoke tobacco? (a) Yes e Cigarettes: # of packs per day: _____
 f Cigars/Pipes: # per day: _____
 - (b) No
 - (2) Smoked in past? (a) Yes Year quit: _____ (b) No
- b Alcohol:
 - (1) How many days per week do you drink beer, wine, or other alcoholic beverages, on average? _____
 - (2) If one beer, one glass of wine, or one cocktail equals one drink, how many drinks do you have, on an average day? _____

c Exercise:

- Do you exercise beyond normal daily activities and chores?
 - (a) Yes Describe the exercise: _____
 - 1. On average, how many days per week do you exercise or do physical activity? _____
 - 2. For how many minutes, on an average day? _____
 - (b) No

21 FAMILY HISTORY (Indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/grandfather, and age of onset if known)

- a Heart disease: _____
- b Hypertension: _____
- c Stroke: _____
- d Diabetes: _____
- e Cancer: _____
- f Psychological: _____
- g Arthritis: _____
- h Osteoporosis: _____
- i Other: _____

Physical Therapy Documentation Samples

Arturo Cuomo



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