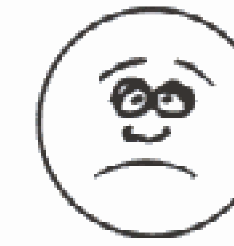
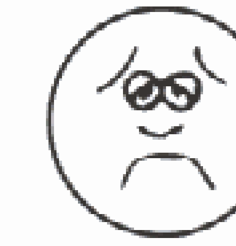
Telephone

Fax

Home Health Agency

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL

					
0 No Hurt	2 Hurts Little Bit	4 Hurts Little More	6 Hurts Even More	8 Hurts Whole Lot	10 Hurts Worst

Patient: ______________________ **Time In** __________ **Time Out** __________

Date: ______________________

Precautions: ______________________

Subjective: ______________________

____

____

Objective: **BP** __________ **Pulse** __________ **NA** __________

Skilled Interventions
ADL Training D2

Feeding __________
Dressing UE __________
Dressing LE __________
Bathing __________
Hygiene / Grooming __________
Toileting __________
Continence __________
Home management __________
Communication __________
Meal preparation __________
Work __________
Play / Leisure __________
Cognitive training __________
Functional transfers __________
Functional mobility __________

Energy conservation __________
Joint protection __________
Other __________
Other __________

MUSCLE RE-EDUCATION D3
Active / Passive ROM
UE Strengthening __________
Endurance __________
Balance __________
Other __________
Other __________
Other __________

PERCEPTUAL MOTOR TRAINING DS

Fine / Gross Motor Coord. D6
Specify: __________

Neurodevelopment Treatment D7
____

SENSORY TREATMENT D8
____

ORTHOTICS / SPLINTING D9
Fabrication __________
Fitting adjustments __________
Other __________
Other __________

ADAPTIVE EQUIPMENT D10
Obtain __________
Training __________
Other __________
Other __________

Other __________

OTHER D7
Teach home exercise program
Teach shopping
Teach cleaning
Teach laundry
Teach equipment usage
Teach orthotics / splinting
Teach safety measures
Teach pain management
Teach joint protection
Other __________
____

Other __________
____

Other __________

Pt. / Caregiver response to treatment:
Verbalizes understanding
Pt. needs further supervision

No response to education
Pt. returns demonstration
Pt. needs further instruction

____

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____

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____

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PLAN: ______________________

____

______________________ ______________________

Therapist Signature **Date** **Patient Signature**