

How to report to the Attending PT

Post History

- A. Patient Profile: demographic info, occupation, behavioral/cognitive status, manner by which physical therapy services were initiated, reason for referral/CC, manner of referral
- B. Account of Current Condition: HPI, MOI, Evaluations, Dx tests, date of onset, tx/course of events since onset, past history of current condition (any related/similar episodes), Medications – OTC or MD Rx, any benefit for current problem, taking as directed, med schedule, dx tests: dates/timing & results
- C. Symptoms: LOCIDAA+
- D. Current Function/Disability: standardized questionnaires
- E. PMH, health Risk Factors: Other Medical Care / hospitalizations or serious illness, Pregnancy, Family history, Potential Red Flags
- F. Other information: Personal and Environmental Factors, Pt goals, contraindications/precautions
- G. Systems Review: Cardiopulmonary, Neuromuscular, Integumentary, Musculoskeletal, Cognitive function

*at the end include 2-3 possibilities of what you think the pathology is. Discuss relevant tests you would like to do and ask for attending's input.

Pre Intervention

- A. Summary Statement
 - probable tissues at fault
 - hypothesis about underlying causes
 - acuity/irritability/severity of problem
 - may include APTA practice pattern, other diagnostic or tx-based classification
- B. Problem list
 - Impairments
 - Functional Limitations

Pre Leaving for the day

- A. Patient Response
 - What exercises the patient did, what was tolerated, what wasn't, what HEP you gave the patient, when you plan to have the patient return, any other pertinent information obtained.

Example

Post History

Pedro Gonzalez is a 45 y/o Ectomorph spanish speaking M, works full time at Discount Repair. CC LBP at L4-L5 paraspinals. Patient reported injuring himself 3 weeks ago while lifting a bag of cement from a palette to a wheelbarrow. Patient reported hearing a pop while extending his back. Pain is a dull ache that comes and goes and reports currently a 7/10 pain on the VRS. Aggravating factors include sitting for over 20 minutes, getting into and out of the car and walking for longer than 30 minutes. Alleviating factors are ice and Ibuprofen. Reports no change over the past 24 hours. 3 years ago patient reported a similar incident lasting only 1 week that got better with ice and medicine. No prior intervention to PT. Patient currently unable to perform IADL's like walking

to the store and going to work. Difficulty with ADL's including putting on his shirt, and helping cook dinner. Patient reports being at a 70% function of normal activity. Patient enjoys running and playing soccer and is currently on a competitive soccer team but unable to play due to pain. Patient reports a hospitalization in 2007 due to an appendectomy. Currently has diabetes and high blood pressure both controlled with medications. No allergies and no yellow flags. Red flags include 1 occasion 2 years ago where he felt dizzy and short of breath after a soccer finals game. Family hx of HBP and heart disease. Difficulty sleeping due to pain but other than current condition appears to be healthy. Patient lives in a duplex and really interested in anything that will help his back. All systems appear to be intact.

We think that it could possibly be a herniated disc or mm. strain. We want to check his ROM, strength, neurological testing and perform a slump test and SLR test. We would like to do some joint play too. Anything else you would add?

Pre Intervention

We believe that he has a second degree mm. strain with sever mm. spasms and guarding due to lifting the bag of cement with improper body mechanics. Patient reports a 7/10 pain and TTP over the lumbar paraspinals No radicular pain.

Upon evaluation we found the patient had mild swelling and redness over the right multifidus c increased mm. tone. Joint clearing all WNL. Lumbar spine AROM limited. Flexion 20 degrees, Extension 10 degrees, SB 10 degrees, rotation 10 degrees. Empty end-feel on all motions. All isometric testing SPF. All LE DTR's normal, All light touch/pinprick dermatomal testing intact, all LE myotomal testing normal. Positive Slump test and Sign of the buttock. Negative SLR B. Joint play-hypomobile segments T12-L1 and L4-L5. Hypermobile at L2-L3. Patient TTP over the lumbar paraspinals with significant guarding and more mm. spasms over the right multifidus.

Patient unable to sit for >20 minutes, walk for >30 minutes and get in and out of his car without onset of pain. Difficulty putting on his shirt and cooking dinner.

We plan on teaching him about ice and other modalities to help relieve his pain and giving him a good HEP with back strengthening exercises. We want to do just a simple pelvic tilt, abdominal strengthening, lat pull downs, LE rotations, Marching. We also plan to cue him on proper lifting. Anything else we should check? Anything else you would add?

Pre leaving for the day

Patient responded well to the pelvic tilts, level 1 marching, lat pull downs and TrA activation. Patient didn't like the LE rotations. We gave him a lot of exercises and a good exercise program to do at home. We explained to him that he would benefit from more PT but wouldn't be able to return for about 3 weeks. He agreed to doing the HEP at home for 3 weeks and contacting Ali to re-schedule another apt. Would you like us to do anything else?