

**Central State Hospital**620 Broad St.  
Milledgeville, GA 31062**PHYSICAL THERAPY EVALUATION****NAME:** \_\_\_\_\_**ADMISSION DATE:** \_\_\_\_\_**ID#:** \_\_\_\_\_**SOURCE(S) OF INFORMATION:**

Interview with the following: (Check only those which apply)

 Individual  Staff member(s) \_\_\_\_\_ Family member(s) or friends \_\_\_\_\_ Review of records (specify): \_\_\_\_\_**REASON FOR EVALUATION:** \_\_\_\_\_**PERTINENT DIAGNOSIS/MEDICATIONS:** \_\_\_\_\_**PERTINENT HISTORY:** \_\_\_\_\_**PREVIOUS ONSET, INTERVENTIONS AND RESPONSE:** \_\_\_\_\_**HIGH RISK CONDITIONS:** \_\_\_\_\_**24 Hour Support Plan:**  Not indicated  Indicated: \_\_\_\_\_**ASSESSMENT(S) ADMINISTERED:** \_\_\_\_\_**PSYCHOSOCIAL FUNCTION:****Affect:**  Appropriate  Labile  Flat  Depressed  Excited  Anxious  Angry**Cooperation:**  Cooperative  Refused to participate in evaluation  Limited: \_\_\_\_\_**Eye contact:**  Appropriate  Absent  Limited: \_\_\_\_\_**Communication:**  Functional  Inappropriate language or tone  Pressured speech  Nonverbal Appears to have receptive and/or expressive language difficulty  Varies across environmental contexts or settings: \_\_\_\_\_**Communication methods:**  Eye gaze  Vocalizations  Facial expressions  Gestures  Sign Language Vocalizations  Picture system  Yes/no responses  AAC Device: \_\_\_\_\_  Words: \_\_\_\_\_ Sentences or phrases: \_\_\_\_\_  Body Language: \_\_\_\_\_**CARDIOVASCULAR AND RESPIRATORY FUNCTION:** Functional  Limited: \_\_\_\_\_**SENSORY AND PERCEPTUAL FUNCTION:****Orientation and mobility:**  Functional  Functional with device and/or techniques  Limited by diminished environmental awareness: \_\_\_\_\_**Auditory acuity:**  Functional  Limited  Functional with corrective device  Refuses prescribed corrective device  Deaf**Vestibular function:**  Functional  Limited: \_\_\_\_\_**Kinesthetic function:**  Functional  Limited: \_\_\_\_\_**Pain:**  No pain reported  Individual nonverbal and does not appear to be in pain  Individual nonverbal but pain suspected: \_\_\_\_\_ Currently experiencing pain (level, location, exacerbating and alleviating factors): \_\_\_\_\_ Pertinent pain history and interventions: \_\_\_\_\_**SKIN INTEGRITY:** Functional  Location(s) and type of current breakdown: \_\_\_\_\_ Skin breakdown potential: \_\_\_\_\_ Edema present: \_\_\_\_\_**MUSCULOSKELETAL FUNCTION:****Range of Motion:**  Functional  Limited; see attached ROM and Strength assessment: \_\_\_\_\_**Strength:**  Functional  Limited; see attached ROM and Strength assessment: \_\_\_\_\_**Joint integrity:**  Functional  Limited: \_\_\_\_\_**Muscle Tone:**  Functional  Hypotonic  Hypertonic  Fluctuating  Flaccid  Hemiplegia 

Diplegia

Explain: \_\_\_\_\_

**Muscular endurance:**  Functional for daily activities  Limited: \_\_\_\_\_

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**GROSS MOTOR FUNCTION:**

**Posture:**

Alignment:  Functional for daily activities  Limited: \_\_\_\_\_  
 Positioning:  Independent  See attached AT Evaluation  Needs assistance: \_\_\_\_\_  
 Body mechanics and Ergonomics:  Functional for daily activities  Limited: \_\_\_\_\_

**SEATING AND POSITIONING:**  Indicated  Not indicated

**Current supports:**  None  List type, usage, adaptations: \_\_\_\_\_

**Mat assessment:**  Indicated  Not indicated

Supine resting, prone, and/or sidelying posture(s): \_\_\_\_\_

Alignment: \_\_\_\_\_

Tone and movement patterns: \_\_\_\_\_

Musculoskeletal involvement: \_\_\_\_\_

**Bed positioning:**  Not indicated  List equipment, turning schedule, positioning specifications: \_\_\_\_\_

**Alternate positioning:**  Not indicated  Sidelying  Quadraped on forearms  Prone on forearms

Other: \_\_\_\_\_

Results: \_\_\_\_\_ Impact of alternate positioning on functional ability, participation and socialization: \_\_\_\_\_

**Wheelchair assessment:**  Indicated  Not indicated Observations: \_\_\_\_\_

**Functional Balance:**

Sitting:  Functional for daily activities  Limited \_\_\_\_\_

Standing:  Functional for daily activities  Unable to stand  Limited: \_\_\_\_\_

Reaching:  Functional for daily activities  Not observed  Limited: \_\_\_\_\_

**Gait, Locomotion, and Motor control:**

Gait:  Functional  Limited: \_\_\_\_\_

Safety awareness during locomotion:  Functional  Limited awareness: \_\_\_\_\_

Precautions:  Not indicated  Indicated but compliance limited  Implemented or recommended: \_\_\_\_\_

Fall Risk Assessment score: \_\_\_\_\_  Not available or not applicable

Transfers:  Functional  Needs assistance: \_\_\_\_\_

Quality of movement and motor control: \_\_\_\_\_

**ORTHOTIC AND PROSTETIC DEVICES:**

Not indicated  Indicated but not utilized  In use or recommended: \_\_\_\_\_

**Activities of Daily Living**

	Functional ability, level of assistance and supervision	Performance components, task demands, and environment	Supports and/or techniques to promote safety and/or independence (Adaptive equipment; Special procedures and techniques; Positioning)
<b>Mobility-Functional distances for self care activities</b>	_____	_____	_____
<b>Mobility-Functional distances for community activities</b>	_____	_____	_____
<b>Transfers</b>	_____	_____	_____
<b>Other:</b>	_____	_____	_____

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**ANALYSIS OF FINDINGS:**  Not indicated; please refer to Integrated Therapy Services Analysis of Findings

**Individual's priorities and life goals:** \_\_\_\_\_

**Present functional status:** \_\_\_\_\_

**Environments, modalities, preferences, and/or strategies that support learning and/or performance or may hinder performance:** \_\_\_\_\_

**Implications for Discharge Planning:** \_\_\_\_\_

**Recommendations for additional assessments or evaluation:**  None  List: \_\_\_\_\_

**Recommended Goal(s):** \_\_\_\_\_

**Recommended Objective(s):** \_\_\_\_\_

**Recommended Intervention(s):** \_\_\_\_\_

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**Signature and date**