chapter two

Meet Joe Lores

Julia Chevan, PT, PhD, MPH, OCS
Phyllis A. Clapis, PT, DHSc, OCS

Joe Lores represents a typical patient seen in a physical therapy clinic with acute low back pain. This chapter provides the reader with the basic history and examination findings from Joe's first day at the clinic.

BACKGROUND

The patient/client management model from the *Guide to Physical Therapist Practice*[1] provides an ideal prototype to structure the data from our patient's presentation. The patient/client management model (Figure 2–1) contains five elements. These elements lead the therapist through a process that results in selection of the most appropriate intervention for the patient and that incorporates and assures that outcomes are evaluated and measured. For Joe, we documented initial history and examination data on a template that was based on the patient/client management model (Figure 2–2). We used a pain diagram (Figure 2–3) to show the location of Joe's symptoms. In an effort to consider the anticipated goals and outcomes of Joe's care, we used the Oswestry Disability Questionnaire as a measure of his functional limitations and limitations in activities of daily living (Figure 2–4). In later chapters of this book you will find Joe's examination data embellished by the information requested from each chapter author, in a manner consistent with the model being described. The additional data requested was provided by the two text authors (Chevan and Clapis) using the patient/client model and then documented, either in narrative form or on a documentation template provided by the chapter author.

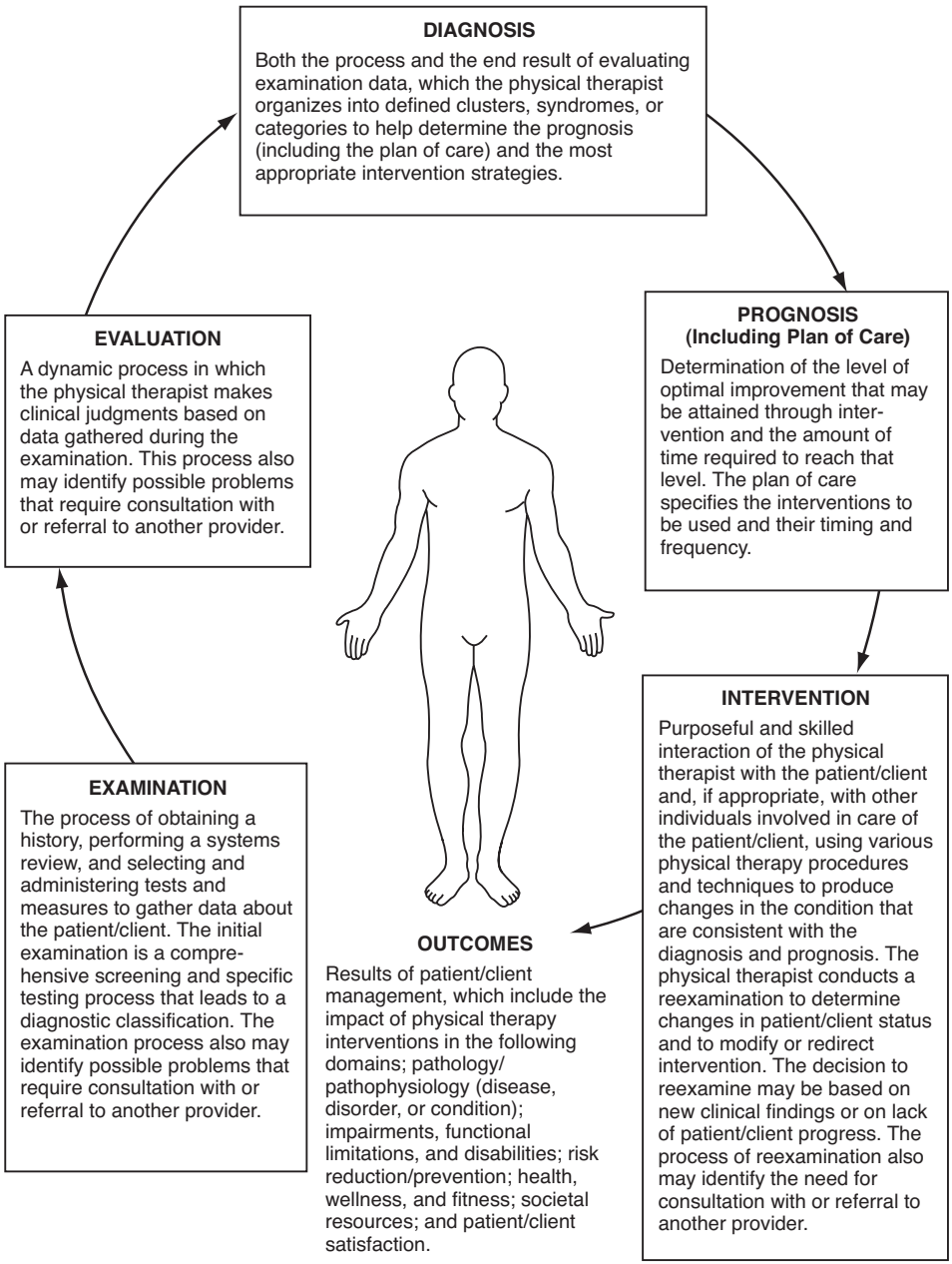


Figure 2–1 Patient/Client Management model. *Source:* Reprinted from *Interactive Guide to Physical Therapist Practice,* 2003, with permission of the American Physical Therapy Association. This material is copyrighted, and any further reproduction or distribution is prohibited.

EXAMINATION

History and Systems Review

Joe is a 37-year-old male who lives in Springfield, Massachusetts. He is of Hispanic descent and speaks and understands Spanish and English. Joe has worked full time as a self-employed plumber since graduating from technical school 14 years ago. He was married at age 23 and became divorced 5 years ago. He currently owns his own home and lives with his 13-year-old son Joey. Joe describes himself as generally healthy, having stopped smoking 11 years ago. He usually drinks one or two cans of beer every day after coming home from work. Although he participated on the varsity wrestling team in high school, he does not exercise regularly. At age 35 Joe was diagnosed with hypertension, for which he is currently taking medication. Additional medical history includes a fractured left clavicle in 1985 and arthroscopic knee surgery in 1986. His family medical history includes heart disease, diabetes, and cancer.

Joe's back pain came on approximately 2 weeks ago, nearly 1 year from the date of his initial back injury, which resolved on its own within a week. Joe was installing a sink, and while bent over, felt immediate pain on the right side of his lower back. He continued to work, but as the day went on the pain travelled into his right buttock. Three days later he saw his primary care physician who ordered an X-ray (which was negative for fracture) and prescribed Flexeril, a muscle relaxant, which he takes at night. He also takes a nonsteroidal anti-inflammatory drug twice daily for pain relief.

In terms of the systems review, Joe had cardiovascular and spinal range of motion impairments. The cardiovascular impairment is related to his blood pressure, which is elevated and being monitored by his physician. The spinal range of motion impairment is presumed to be related to his back pain, the reason he pursued physical therapy. Joe's height and weight corresponded to a body mass index of 28, which is considered overweight. Joe reported that he learned best through pictures and demonstration.

Tests and Measures

Posture: Joe presented with no significant postural deformities. His pelvis was level and his lumbar lordosis was slightly reduced. Both patellae were "frog eyed," meaning they were pointed outward.

Range of Motion: Active and passive movements were assessed. Actively, Joe presented with a 50% loss in flexion and extension, with both movements increasing his symptoms. Sidebending to the right and rotation to the left were also slightly limited, with both movements also increasing symptoms.

Left side bending and right rotation were pain free and range of motion was full. Passive extension was tested in prone, revealed a 25% limitation, and was painful. Flexion in supine (knees to chest) was full yet elicited pain.

Neurological Exam: Joe presented with no neurological deficits. Sensation, myotomal strength, and reflexes were within normal limits.

Palpation: There was palpable fullness in the right lumbar paravertebrals. There was also visible and palpable muscle guarding in the right lower back region.

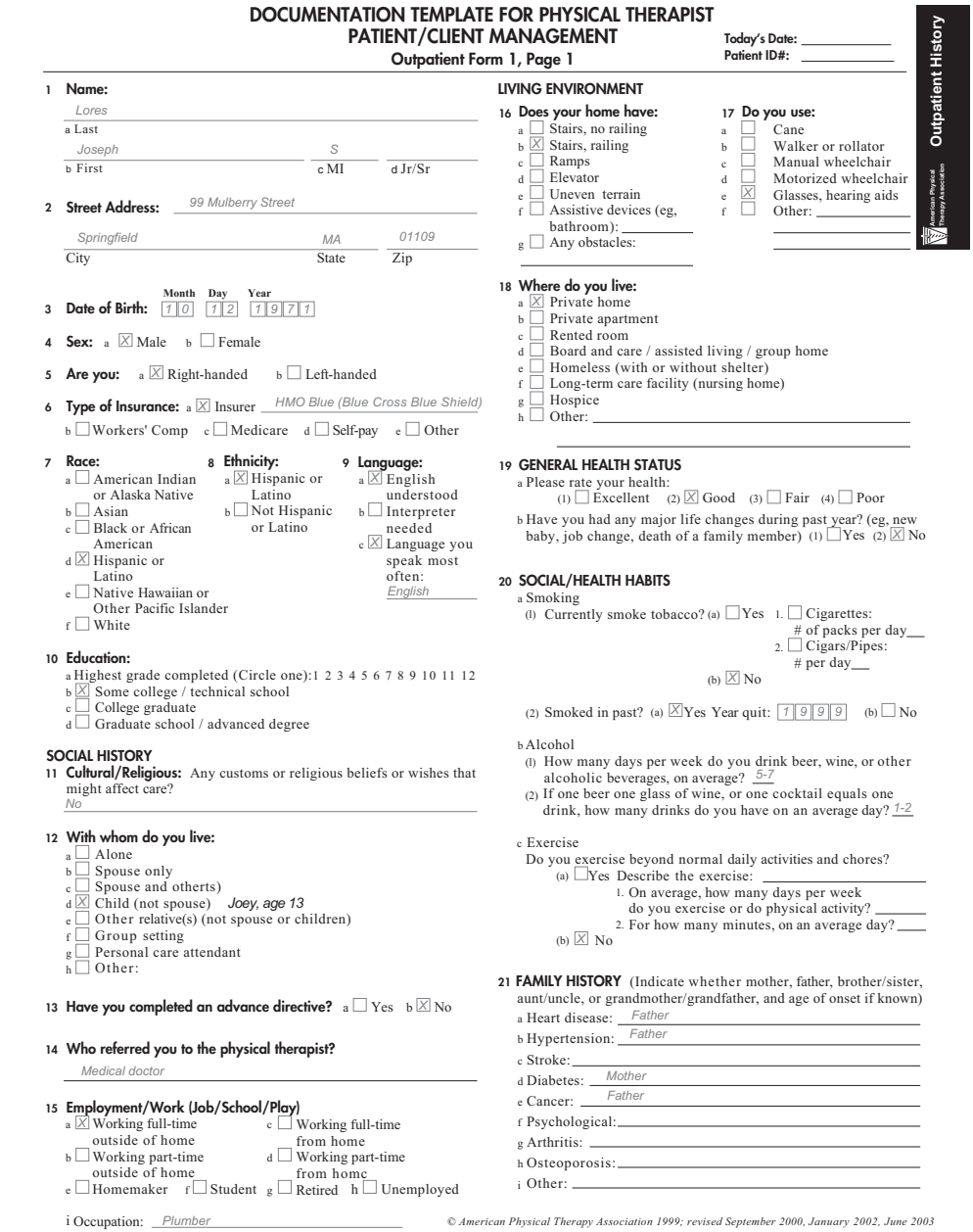
Joe scored 42% on the Modified Oswestry Disability Questionnaire.[2] This reflects a moderate degree of disability. Accordingly, Joe's greatest difficulties are in sitting, a task that he can only do for less than 10 minutes due to his pain level, and in lifting. It is notable that for Joe, all the tasks of the Oswestry are affected by his current bout of low back pain (LBP). Therapists using the Oswestry for an initial measure and goal development should do so with consideration for the minimum clinically important difference, which has been calculated as a six-point change.[2]

EVALUATION

Evaluation is a process in which the therapist renders a clinical judgment based on the data gathered. Since the data we have presented thus far is only partially completed, the evaluation is limited to classifying Joe into one of the "Musculoskeletal Preferred Practice Patterns" from the *Guide to Physical Therapist Practice*.[1] Thus, Joe is classified into Pattern 4F: "Impaired Joint Mobility, Motor Function, Muscle Performance, Range of Motion, and Reflex Integrity Associated with Spinal Disorders."[3]

THE NEXT STEPS

Further data is needed to complete the picture of Joe in the patient/client management model. This data includes additional information in his history and additional tests and measures. Our hypothesis in writing this textbook is that although all the theories and models used in musculoskeletal physical therapy have some commonalities, they differ not only in intervention choices but also in examination schema. As a result, we have structured Joe's exam so that each chapter author will need to lay out the examination in accordance to their specific model. In the next chapters the student should take note of how the examination leads into a process of evaluation, a resultant diagnosis, the determination of a prognosis, and the selection of interventions.



DOCUMENTATION TEMPLATE FOR PHYSICAL THERAPIST PATIENT/CLIENT MANAGEMENT
Outpatient Form 1, Page 1

Today's Date: _____
Patient ID#: _____

Outpatient History — American Physical Therapy Association

1 Name:
Lores
a Last
Joseph | S | _____
b First | c MI | d Jr/Sr

2 Street Address: 99 Mulberry Street
Springfield | MA | 01109
City | State | Zip

3 Date of Birth: Month 10 Day 12 Year 1971

4 Sex: a ☒ Male b ☐ Female

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

6 Type of Insurance: a ☒ Insurer HMO Blue (Blue Cross Blue Shield)
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: English

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?
No

12 With whom do you live:
a ☐ Alone
b ☐ Spouse only
c ☐ Spouse and others)
d ☒ Child (not spouse) Joey, age 13
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?
Medical doctor

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: Plumber

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 1. ☐ Cigarettes: # of packs per day___
2. ☐ Cigars/Pipes: # per day___
(b) ☒ No
(2) Smoked in past? (a) ☒ Yes Year quit: 1999 (b) ☐ No

b Alcohol
(1) How many days per week do you drink beer, wine, or other alcoholic beverages, on average? 5-7
(2) If one beer one glass of wine, or one cocktail equals one drink, how many drinks do you have on an average day? 1-2

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: Father
b Hypertension: Father
c Stroke: _____
d Diabetes: Mother
e Cancer: Father
f Psychological: _____
g Arthritis: _____
h Osteoporosis: _____
i Other: _____

Figure 2–2 Documentation template for physical therapist patient/client management. *Source:* Reprinted from *Interactive Guide to Physical Therapist Practice,* 2003, with permission of the American Physical Therapy Association. This material is copyrighted, and any further reproduction or distribution is prohibited.

DOCUMENTATION TEMPLATE FOR PHYSICAL THERAPIST PATIENT/CLIENT MANAGEMENT
Outpatient Form , Page 2

22 MEDICAL/SURGICAL HISTORY

a Please check if you have ever had:

(1) ☐ Arthritis
(2) ☒ Broken bones/ fractures *Clavicle, 1985*
(3) ☐ Osteoporosis
(4) ☐ Blood disorders
(5) ☐ Circulation/vascular problems
(6) ☐ Heart problems
(7) ☒ High blood pressure
(8) ☐ Lung problems
(9) ☐ Stroke
(10) ☐ Diabetes/ high blood sugar
(11) ☐ Low blood sugar/ hypoglycemia
(12) ☐ Head injury
(13) ☐ Multiple sclerosis
(14) ☐ Muscular dystrophy
(15) ☐ Parkinson disease
(16) ☐ Seizures/epilepsy
(17) ☐ Allergies
(18) ☐ Developmental or growth problems
(19) ☐ Thyroid problems
(20) ☐ Cancer
(21) ☐ Infectious disease (eg, tuberculosis, hepatitis)
(22) ☐ Kidney problems
(23) ☐ Repeated infections
(24) ☐ Ulcers/stomach problems
(25) ☐ Skin diseases
(26) ☐ Depression
(27) ☐ Other: _____

b Within the past year, have you had any of the following symptoms? (Check all that apply)

(1) ☐ Chest pain
(2) ☐ Heart palpitations
(3) ☐ Cough
(4) ☐ Hoarseness
(5) ☐ Shortness of breath
(6) ☐ Dizziness or blackouts
(7) ☐ Coordination problems
(8) ☐ Weakness in arms or legs
(9) ☐ Loss of balance
(10) ☐ Difficulty walking
(11) ☒ Joint pain or swelling *knees*
(12) ☐ Pain at night
(13) ☐ Difficulty sleeping
(14) ☐ Loss of appetite
(15) ☐ Nausea/vomiting
(16) ☐ Difficulty swallowing
(17) ☐ Bowel problems
(18) ☐ Weight loss/gain
(19) ☐ Urinary problems
(20) ☐ Fever/chills/sweats
(21) ☐ Headaches
(22) ☐ Hearing problems
(23) ☐ Vision problems
(24) ☐ Other: _____

c Have you ever had surgery? (1) ☒ Yes (2) ☐ No
If yes, please describe, and include dates:

	Month	Year
Knee arthroscope	1 1	1 9 8 6
	☐☐	☐☐☐☐
	☐☐	☐☐☐☐

For men only: d Have you been diagnosed with prostate disease? (1) ☐ Yes (2) ☒ No

For women only:
Have you been diagnosed with:
e Pelvic inflammatory disease? (1) ☐ Yes (2) ☐ No
f Endometriosis? (1) ☐ Yes (2) ☐ No
g Trouble with your period? (1) ☐ Yes (2) ☐ No
h Complicated pregnancies or deliveries? (1) ☐ Yes (2) ☐ No
i Pregnant, or think you might be pregnant? (1) ☐ Yes (2) ☐ No
j Other gynecological or obstetrical difficulties? (1) ☐ Yes (2) ☐ No
If yes, please describe: _____

23 CURRENT CONDITION(S)/CHIEF COMPLAINT(S)

a Describe the problem(s) for which you seek physical therapy:
Right sided low back pain and right buttock pain

b When did the problem(s) begin (date)? Month ☐☐ Year ☐☐☐☐ *Started 2 months ago*

c What happened? *Installing a sink, when putting the sink in he felt a sudden pain*

d Have you ever had the problem(s) before?
(1) ☒ Yes
(a) What did you do for the problem(s)? *Rested, took Tylenol*
(b) Did the problem(s) get better?
1. ☒ Yes 2. ☐ No
(c) About how long did the problem(s) last? *One week*
(2) ☐ No

23 Current Condition(s)/Chief Complaint(s) (continued)

e How are you taking care of the problem(s) now? *Saw MD. taking medication*

f What makes the problem(s) better? *Lying down, rest*

g What makes the problem(s) worse? *Sitting, bending, many tasks at work, getting up from sitting, lifting*

h What are your goals for physical therapy? *Get rid of the pain; be able to work pain-free*

i Are you seeing anyone else for the problem(s)? (Check all that apply)

(1) ☐ Acupuncturist
(2) ☐ Cardiologist
(3) ☐ Chiropractor
(4) ☐ Dentist
(5) ☐ Family practitioner
(6) ☐ Internist
(7) ☐ Massage therapist
(8) ☐ Neurologist
(9) ☐ Obstetrician/gynecologist
(10) ☐ Occupational therapist
(11) ☐ Orthopedist
(12) ☐ Osteopath
(13) ☐ Pediatrician
(14) ☐ Podiatrist
(15) ☒ Primary care physician
(16) ☐ Rheumatologist
Other: _____

24 FUNCTIONAL STATUS/ACTIVITY LEVEL (Check all that apply)

a ☐ Difficulty with locomotion/movement:
(1) ☐ Bed mobility
(2) ☐ Transfers (such as moving from bed to chair, from bed to commode)
(3) ☐ Gait (walking)
(a) ☐ On level (c) ☐ On ramps
(b) ☐ On stairs (d) ☐ On uneven terrain
b ☐ Difficulty with self-care (such as bathing, dressing, eating, toileting)
c ☒ Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)
d ☒ Difficulty with community and work activities/integration
(1) ☒ Work/school *Plumber tasks*
(2) ☐ Recreation or play activity

25 MEDICATIONS

a Do you take any prescription medications? (1) ☒ Yes (2) ☐ No
If yes, please list: *Lotensin. Flexeril*

b Do you take any nonprescription medications? (Check all that apply)

(1) ☒ Advil/Aleve
(2) ☐ Antacids
(3) ☐ Ibuprofen/ Naproxen
(4) ☐ Antihistamines
(5) ☐ Aspirin
(6) ☐ Decongestants
(7) ☐ Herbal supplements
(8) ☐ Tylenol
(9) ☐ Other: _____

c Have you taken any medications previously for the condition for which you are seeing the physical therapist?
(1) ☐ Yes (2) ☒ No If yes, please list: _____

26 OTHER CLINICAL TESTS Within the past year, have you had any of the following tests? (Check all that apply)

a ☐ Angiogram
b ☐ Arthroscopy
c ☐ Biopsy
d ☐ Blood tests
e ☐ Bone scan
f ☐ Bronchoscopy
g ☐ CT scan
h ☐ Doppler ultrasound
i ☐ Echocardiogram
j ☐ EEG (electroencephalogram)
k ☐ EKG (electrocardiogram)
l ☐ EMG (electromyogram)
m ☐ Mammogram
n ☐ MRI
o ☐ Myelogram
p ☐ NCV (nerve conduction velocity)
q ☐ Pap smear
r ☐ Pulmonary function test
s ☐ Spinal tap
t ☐ Stool tests
u ☐ Stress test (eg, treadmill, bicycle)
v ☐ Urine tests
w ☒ X-rays
x ☐ Other: _____

Figure 2–2 Documentation template for physical therapist patient/client management (continued).

DOCUMENTATION TEMPLATE FOR PHYSICAL THERAPIST PATIENT/CLIENT MANAGEMENT

Systems Review

Systems Review

	Not Impaired	Impaired
CARDIOVASCULAR/PULMONARY SYSTEM	☐	☒
Blood pressure: 135/85		
Edema: None noted		
Heart rate: 68		
Respiratory rate: 12		
Patient's blood pressure controlled by medication and diet		
INTEGUMENTARY SYSTEM	☒	☐
Integrity		
Pliability (texture): Normal		
Presence of scar formation: None noted		
Skin color: Normal		
Skin integrity: Normal		

	Not Impaired	Impaired
MUSCULOSKELETAL SYSTEM		
Gross Range of Motion	☐	☒
Gross Strength	☒	☐
Gross Symmetry	☐	☐
Standing: Grossly symmetrical		
Sitting: Grossly symmetrical		
Activity specific:		
Other:		

Height 5' 10"

Weight 195 lbs

	Not Impaired	Impaired
NEUROMUSCULAR SYSTEM		
Gross Coordinated Movements		
Balance	☒	☐
Gait	☒	☐
Locomotion	☒	☐
Transfers	☒	☐
Transitions	☒	☐
Motor function (motor control, motor learning)	☒	☐

COMMUNICATION, AFFECT, COGNITION, LEARNING STYLE		
Communication (eg, age-appropriate)	☒	☐
Orientation x 3 (person/place/time)	☒	☐
Emotional/behavioral responses	☒	☐

Learning barriers:
- ☒ None
- ☐ Vision
- ☐ Hearing
- ☐ Unable to read
- ☐ Unable to understand what is read
- ☐ Language/needs interpreter
- ☐ Other: _____

Education needs:
- ☒ Disease process
- ☐ Safety
- ☐ Use of devices/equipment
- ☒ Activities of daily living
- ☒ Exercise program
- ☐ Other: _____

How does patient/client best learn? ☒ Pictures ☐ Reading ☐ Listening ☒ Demonstration ☐ Other:

Figure 2–2 Documentation template for physical therapist patient/client management (continued).

DOCUMENTATION TEMPLATE FOR PHYSICAL THERAPIST PATIENT/CLIENT MANAGEMENT
Tests and Measures

American Physical Therapy Association **Tests and Measures**

KEY TO TESTS AND MEASURES:

1 Aerobic Capacity/Endurance
2 Anthropometric Characteristics
3 Arousal, Attention, and Cognition
4 Assistive and Adaptive Devices
5 Circulation (Arterial, Venous, Lymphatic)
6 Cranial and Peripheral Nerve Integrity
7 Environmental, Home, and Work (Job/School/Play) Barriers
8 Ergonomics and Body Mechanics
9 Gait, Locomotion, and Balance
10 Integumentary Integrity
11 Joint Integrity and Mobility
12 Motor Function (Motor Control and Motor Learning)
13 Muscle Performance (Including Strength, Power, and Endurance)
14 Neuromotor Development and Sensory Integration
15 Orthotic, Protective, and Supportive Devices
16 Pain
17 Posture
18 Prosthetic Requirements
19 Range of Motion (Including Muscle Length)
20 Reflex Integrity
21 Self-Care and Home Management (Including Activities of Daily Living and Instrumental Activities of Daily Living)
22 Sensory Integrity
23 Ventilation and Respiration/Gas Exchange
24 Work (Job/School/Play), Community, and Leisure Integration or Reintegration (Including Instrumental Activities of Daily Living)

NOTES:

Posture

In standing: Iliac crestis. ASIS and PSIS all even

Lumbar lordosis is slightly reduced

Frog eyed patellae

Active ROM

Flexion 50% increases symptoms

Extension 50% increases symptoms

Side bend right 75% increases symptoms

Side bend left 100%

Rotation left 80%

Rotation right 100%

Passive ROM

Prone extension 75% increases symptoms

Supine flexion 100% increases symptoms

Neurologic Screen

Sensation testing by dermatome is bilateral normal

Reflexes are bilateral symmetrical with 2+ Patellar and Achilles

Strength by myotome level is bilateral normal

SLR is negative

Palpation

Increased fullness noted in right paravertebral region

Marked muscle guarding on right

Figure 2–2 Documentation template for physical therapist patient/client management (continued).

DOCUMENTATION TEMPLATE FOR PHYSICAL THERAPIST PATIENT/CUENT MANAGEMENT

Evaluation

Evalution

American Physical Therapy Association

PREFERRED PHYSICAL THERAPIST PRACTICE PATTERNS[SM]

DIAGNOSIS:

Musculoskeletal Patterns

- ☐ A: Primary Prevention/Risk Reduction for Skeletal Demineralization
- ☐ B: Impaired Posture
- ☐ C: Impaired Muscle Performance
- ☐ D: Impaired Joint Mobility, Motor Function, Muscle Performance, and Range of Motion Associated With Connective Tissue Dysfunction
- ☐ E: Impaired Joint Mobility, Motor Function, Muscle Performance, and Range of Motion Associated With Localized Inflammation
- ☒ F: Impaired Joint Mobility, Motor Function, Muscle Performance, Range of Motion, and Reflex Integrity Associated With Spinal Disorders
- ☐ G: Impaired Joint Mobility, Muscle Performance, and Range of Motion Associated With Fracture
- ☐ H: Impaired Joint Mobility, Motor Function, Muscle Performance, and Range of Motion Associated With Joint Arthroplasty
- ☐ I: Impaired Joint Mobility, Motor Function, Muscle Performance, and Range of Motion Associated With Bony or Soft Tissue Surgery
- ☐ J: Impaired Motor Function, Muscle Performance, Range of Motion, Gait, Locomotion, and Balance Associated With Amputation

Neuromuscular Patterns

- ☐ A: Primary Prevention/Risk Reduction for Loss of Balance and Falling
- ☐ B: Impaired Neuromotor Development
- ☐ C: Impaired Motor Function and Sensory Integrity Associated With Nonprogressive Disorders of the Central Nervous System—Congenital Origin or Acquired in Infancy or Childhood
- ☐ D: Impaired Motor Function and Sensory Integrity Associated With Nonprogressive Disorders of the Central Nervous System—Acquired in Adolescence or Adulthood
- ☐ E: Impaired Motor Function and Sensory Integrity Associated With Progressive Disorders of the Central Nervous System
- ☐ F: Impaired Peripheral Nerve Integrity and Muscle Performance Associated With Peripheral Nerve Injury
- ☐ G: Impaired Motor Function and Sensory Integrity Associated With Acute or Chronic Polyneuropathies
- ☐ H: Impaired Motor Function, Peripheral Nerve Integrity, and Sensory Integrity Associated With Nonprogressive Disorders of the Spinal Cord
- ☐ I: Impaired Arousal, Range of Motion, and Motor Control Associated With Coma, Near Coma, or Vegetative State

Cardiovascular/Pulmonary Patterns

- ☐ A: Primary Prevention/Risk Reduction for Cardiovascular/Pulmonary Disorders
- ☐ B: Impaired Aerobic Capacity/Endurance Associated With Deconditioning
- ☐ C: Impaired Ventilation, Respiration/Gas Exchange, and Aerobic Capacity/Endurance Associated With Airway Clearance Dysfunction
- ☐ D: Impaired Aerobic Capacity/Endurance Associated With Cardiovascular Pump Dysfunction or Failure
- ☐ E: Impaired Ventilation and Respiration/Gas Exchange Associated With Ventilatory Pump Dysfunction or Failure
- ☐ F: Impaired Ventilation and Respiration/Gas Exchange Associated With Respiratory Failure
- ☐ G: Impaired Ventilation, Respiration/Gas Exchange, and Aerobic Capacity/Endurance Associated With Respiratory Failure in the Neonate
- ☐ H: Impaired Circulation and Anthropometric Dimensions Associated With Lymphatic System Disorders

Integumentary Patterns

- ☐ A: Primary Prevention/Risk Reduction for Integumentary Disorders
- ☐ B: Impaired Integumentary Integrity Associated With Superficial Skin Involvement
- ☐ C: Impaired Integumentary Integrity Associated With Partial-Thickness Skin Involvement and Scar Formation
- ☐ D: Impaired Integumentary Integrity Associated With Full-Thickness Skin Involvement and Scar Formation
- ☐ E: Impaired Integumentary Integrity Associated With Skin Involvement Extending Into Fascia, Muscle, or Bone and Scar Formation

PROGNOSIS: _____

Figure 2–2 Documentation template for physical therapist patient/client management (continued).

DOCUMENTATION TEMPLATE FOR PHYSICAL THERAPIST PATIENT/CLIENT MANAGEMENT
Plan of Care

Plan of Care

American Physical Therapy Association

Anticipated Goals: _____

Expected Outcomes: _____

Interventions: _____

Frequency of Visits/Duration of Episode of Care: _____

Education (including safety, exercise, and disease information): _____

Who was educated? ☐ Patient/client ☐ Family (name and relationship): _____
How did patient/family demonstrate learning:
- ☐ Patient/client verbalized understanding
- ☐ Family/significant other verbalized understanding
- ☐ Patient/client demonstrated correctly
- ☐ Demonstration was unsuccessful (describe): _____

Discharge Plan: _____

Figure 2–2 Documentation template for physical therapist patient/client management (continued).

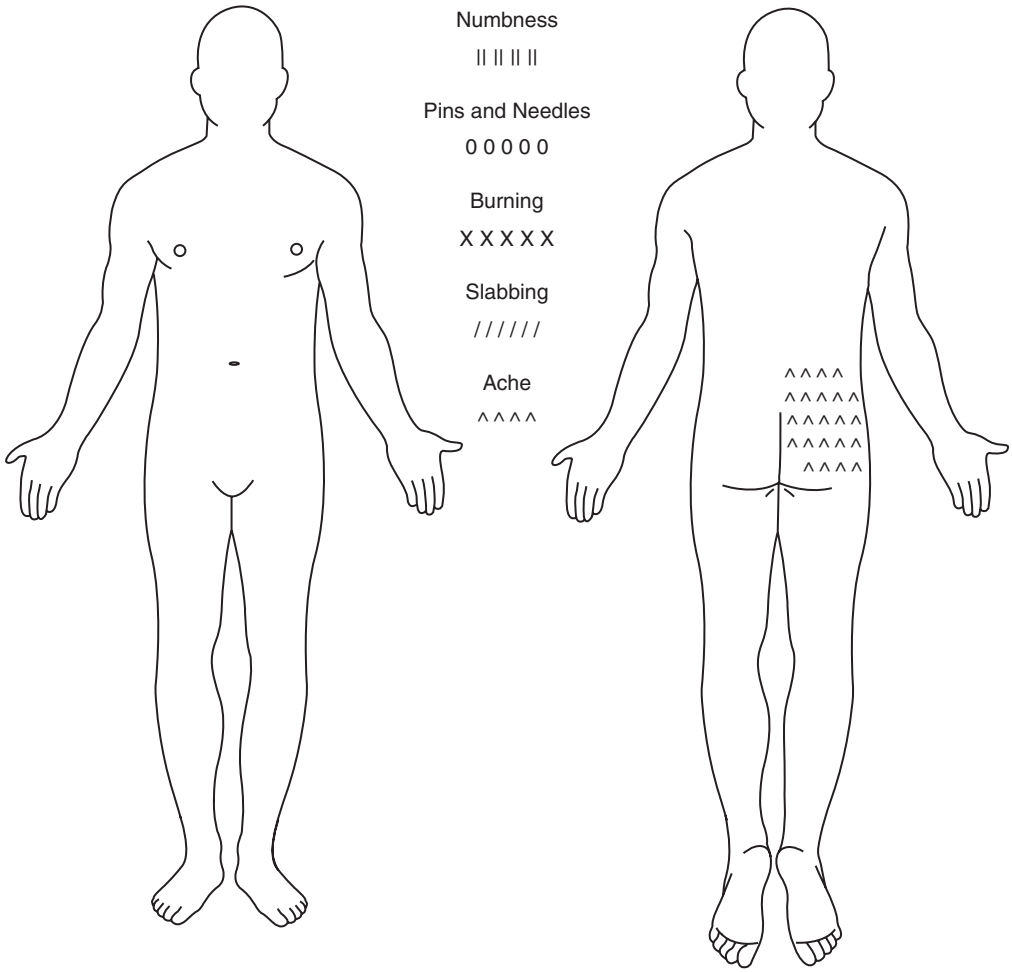


Figure 2–3 Joe's pain diagram.

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in everyday life. Please answer every question by placing a mark in the one box that best describes your condition today. We realize you may feel that 2 of the statements may describe your condition, but please mark only the box that most closely describes your current condition.

Pain Intensity

- ❑ I can tolerate the pain I have without having to use pain medication.
- ❑ The pain is bad, but I can manage without having to take pain medication.
- ❑ Pain medication provides me with complete relief from pain.
- ☑ Pain medication provides me with moderate relief from pain. Value: 3
- ❑ Pain medication provides me with little relief from pain.
- ❑ Pain medication provides has no effect on my pain.

Personal Care (eg, Washing, Dressing)

- ❑ I can take care of myself normally without causing increased pain.
- ❑ I can take care of myself normally, but it increases my pain.
- ☑ It is painful to take care of myself, and I am slow and careful.
- ❑ I need help, but I am able to manage most of my personal care.
- ❑ I need help everyday in most aspects of my care.
- ❑ I do not get dressed, wash with difficulty, and stay in bed.

Lifting

- ❑ I can lift heavy weights without increased pain.
- ❑ I can lift heavy weights, but it causes increased pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (eg, on a table).
- ☑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. Value: 3
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

Walking

- ❑ Pain does not prevent me from walking any distance.
- ☑ Pain prevents me from walking more than 1 mile. Value: 1
- ❑ Pain prevents me from walking more than ½ mile.
- ❑ Pain prevents me from walking more than ¼ mile.
- ❑ I can only walk with crutches or a cane.
- ❑ I am in bed most of the time and have to crawl to the toilet.

Sitting

- ❑ I can sit in any chair as long as I like.
- ❑ I can only sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hour.
- ❑ Pain prevents me from sitting for more than ½ hour.
- ☑ Pain prevents me from sitting for more than 10 minutes. Value: 4
- ❑ Pain prevents me from sitting at all.

Figure 2–4 Modified Oswestry Low Back Pain Questionnaire: Joe Lores.

Standing

- ❑ I can stand as long as I want without increased pain.
- ❑ I can stand as long as I want, but it increases my pain.
- ☑ Pain prevents me from standing more than 1 hour. **Value: 2**
- ❑ Pain prevents me from standing more than ½ hour.
- ❑ Pain prevents me from standing more than 10 minutes.
- ❑ Pain prevents me from standing at all.

Sleeping

- ❑ Pain does not prevent me from sleeping well.
- ☑ I can sleep well only by using pain medication. **Value: 1**
- ❑ Even when I take pain medication, I sleep less than 6 hours.
- ❑ Even when I take pain medication, I sleep less than 4 hours.
- ❑ Even when I take pain medication, I sleep less than 2 hours.
- ❑ Pain prevents me from sleeping at all.

Social Life

- ❑ My social life is normal and does not increase my pain.
- ❑ My social life is normal, but it increases my level of pain.
- ☑ Pain prevents me from participating in more energetic activities (eg, sports dancing). **Value: 2**
- ❑ Pain prevents me from going out very often.
- ❑ Pain has restricted my social life to my home.
- ❑ I have hardly any social life because of my pain.

Traveling

- ❑ I can travel anywhere without increased pain.
- ☑ I can travel anywhere, but it increases my pain. **Value: 1**
- ❑ My pain restricts my travel over 2 hours.
- ❑ My pain restricts my travel over 1 hour.
- ❑ My pain restricts my travel to short necessary journeys under ½ hour.
- ❑ My pain prevents all travel except for visits to the physician/therapist or hospital.

Employment/Homemaking

- ❑ My normal homemaking/job activities do not cause pain.
- ❑ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ☑ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg, lifting, vacuuming). **Value: 2**
- ❑ Pain prevents me from doing anything but light duties.
- ❑ Pain prevents me from doing even light duties.
- ❑ Pain prevents me from performing any job or homemaking chores.

Modified Oswestry Score = 3+2+3+1+4+2+1+2+1+2 = 21/50

42%

Figure 2–4 Modified Oswestry Low Back Pain Questionnaire: Joe Lores (continued).

REFERENCES

1. American Physical Therapy Association. Guide to Physical Therapist Practice. *Phys Ther*. 1997;77:1163–1650.
2. Fritz JM, Irrgang JJ. A comparison of a modified Oswestry Low Back Pain Disability Questionnaire and the Quebec Back Pain Disability Scale. *Phys Ther*. 2001;81(2):776–788.
3. American Physical Therapy Association. *Interactive Guide to Physical Therapist Practice.* Alexandra, VA: American Physical Therapy Association, 2003. Available at http://guidetopractice.apta.org