

MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE	ORTHOPEDIC AND PHYSICAL THERAPY SPORTS CLINIC - KNEE EVALUATION	OTSG APPROVED (Date)
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PART I - SUBJECTIVE

1. Age	2. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	3. Occupation	4. Date of injury	5. Chief complaint
6. Method of injury <input type="checkbox"/> Unsure <input type="checkbox"/> Twisting <input type="checkbox"/> Direct blow <input type="checkbox"/> Overuse <input type="checkbox"/> Other:				7. Is the injury recurrent? <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Comments:		9. Past treatment history:		
10. Pain increases with:		10. Pain decreases with:		12. Pain: ___/10 at rest; ___/10 w/activity
13. Meds:				14. X-rays:
15. Special questions: Locking + - Give way + - Immediate swelling + - Popping + - Immediate WB after trauma + -				
16. Past medical history				17. Patient's goal

PART II - OBJECTIVE

18. Barriers to learning <input type="checkbox"/> None			19. Extremity involved	
20. Observation:				
a. Swelling <input type="checkbox"/> I+ <input type="checkbox"/> II+ <input type="checkbox"/> III+ <input type="checkbox"/> WNL		b. Gait <input type="checkbox"/> Normal <input type="checkbox"/> Antalgic <input type="checkbox"/> Asst device		c. Brace <input type="checkbox"/> No <input type="checkbox"/> Yes:
d. Quad tone <input type="checkbox"/> Symmetrical <input type="checkbox"/> Diminished <input type="checkbox"/> Ecchymosis: + - Location:			e. Neurovascular <input type="checkbox"/> Intact <input type="checkbox"/> Abnormal	
FLEX: EXT: SPECIAL TESTS:				
AROM: _____		Lachman's + - N/A		End feel <input type="checkbox"/> Firm <input type="checkbox"/> Soft
PROM: _____		Post drawer + - N/A		Ant drawer + - N/A
MMT: _____		Bounce home + - N/A		Pivot shift + - N/A
		Apprehension + - N/A		Valgus + _____ - N/A
				Varus + _____ - N/A
21. Tenderness:			22. Cleared hip/ankle:	
23. Functional:				
a. Single leg stand - eyes open: R _____ L _____		b. Single leg stand - eyes closed: R _____ L _____		c. 1/4 squat: <input type="checkbox"/> Yes <input type="checkbox"/> No
24. Muscle lengths (Select all that are tight.) <input type="checkbox"/> Hip flexors <input type="checkbox"/> ITB <input type="checkbox"/> Quadriceps <input type="checkbox"/> Hip ER <input type="checkbox"/> Hamstring <input type="checkbox"/> Gastrocnemius			25. Other	

PART III - ASSESSMENT

26. Comments

PART IV - PLAN

27. The patient or significant other was instructed in basic knee exercises and RICE concept, and has demonstrated or verbalized understanding of the exercise program, precautions and use of ice. Will comply with treatment plan. _____ (Initials)	
28. Treatment goals, options, risks and benefits were discussed with the patient or significant other. The patient or significant other concurs with the treatment plan and goals. _____ (Initials)	
29. Discharge criteria: meeting established goals, maximum benefit achieved, and/or as per protocol. _____ (Initials)	
30. In-clinic treatment: (Select all that apply.) <input type="checkbox"/> N/A <input type="checkbox"/> See MEDDAC Form 696, Physical Therapy Treatment Note <input type="checkbox"/> Daily <input type="checkbox"/> Three times per week <input type="checkbox"/> Two times per week	
31. Follow up on:	32. Profile:

PART V - GOALS

33. Short-term goal. Patient demonstrated exercises properly and can verbalize precautions. <input type="checkbox"/> Achieved <input type="checkbox"/> Not achieved	
34. Long-term goal	

(Continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
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PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)	<input type="checkbox"/> HISTORY/PHYSICAL <input type="checkbox"/> FLOW CHART <input checked="" type="checkbox"/> OTHER EXAMINATION OR EVALUATION <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/> DIAGNOSTIC STUDIES <input type="checkbox"/> TREATMENT
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