Physical Therapy Documentation Cheat Sheet

Physical therapy documentation is an essential part of a physical therapist's job. It records the patient's progress and helps in communication with other healthcare professionals and insurance companies.

Abbreviations

Abbreviations can help save time and space in physical therapy documentation. However, it is essential to use them correctly and consistently. Here are some commonly used abbreviations in physical therapy documentation:

Letter A	
Abbreviation	**Definition**
AAROM	Active assisted range of motion
ABD	Abduction
AC	Acromioclavicular joint
ACDF	Anterior cervical discectomy and fusion
ADL	Activities of daily living
AFO	Ankle foot orthotic
AKA	Above knee amputation
AP	Anterior to posterior
APTA	American Physical Therapy Association
AROM	Active range of motion
Letter B	
Abbreviation	**Definition**
BAPS	Biomechanical ankle platform system
BFRT	Blood flow restriction training
BID/BIW	Twice a day/Twice a week
BKA	Below knee amputation
b/l	Bilateral
BOS	Base of support
BOS	Beginning of session
BP	Blood pressure
BPPV	Benign paroxysmal positional vertigo
Letter C	
Abbreviation	**Definition**
cc	Cable column
CCP	Cervical cold pack
CEU	Continuing Education Unit
CHP	Cervical hot pack
CP	Cold pack
CPT	Current Procedural Terminology
CVAD	Central venous access devices
cx	Cancel
CX or CS	Cervical spine

Letter D	
Abbreviation	**Definition**
DA	Direct access
DB	Dumbbell
DDD	Degenerative disc disease
DFM	Degenerative joint disease
DKTC	Double knee to chest
DLS	Double limb support
DNF	Deep neck flexors
DPC	Digital patient care
Letter E	
Abbreviation	**Definition**
ECG or EKG	Electrocardiogram
EDS	Ehlers-Danlos syndrome
EIL	Extension in lying
EIS	Extension in standing
EOB	Edge of bed
EOS	End of session
ER	External rotation
ES	Electrical stimulation
Letter F	
Abbreviation	**Definition**
FAI	Femoroacetabular impingement
FIL	Flexion in lying
FMS	Functional movement screen
FOB	Foot of bed
FOM	Functional outcome measure
Letter G	
Abbreviation	**Definition**
GH	Glenohumeral joint
GIRD	Glenohumeral internal rotation deficit
Letter H	
Abbreviation	**Definition**
HABD	Horizontal abduction
HADD	Horizontal adduction
HBB	Hand behind back

Letter H	
Abbreviation	**Definition**
HBB	Hand behind back
HEP	Home exercise program
HHA	Home Health Aide
HHVBP	Home Health Value-Based Purchasing
HOB	Head of bed
HP	Hot pack
HR	Heart rate
Hx	History of
Letter I	
Abbreviation	**Definition**
IASTM	Instrument-assisted soft tissue mobilization
IM	Intramuscular
IM	Intramedullary
IPC	Intermittent pneumatic compression
IR	Internal rotation
IV	Intravenous
Letter J	
Abbreviation	**Definition**
JAMAR	Hand/grip dynamometer
Letter K	
Abbreviation	**Definition**
KTC	Knee to chest
Letter J	
Abbreviation	**Definition**
LCP	Large cold pack
LHP	Large hot pack
LJL	Lateral joint line
LMS	Learning management system
LOB	Loss of balance
LOC	Loss of consciousness
LOS	Length of stay
LS or LX	Lumbar spine
LTG	Long-term goal
LTR	Lateral trunk rotation
Letter M	
Abbreviation	**Definition**
MC	Medicare
MHP	Moist hot pack

Letter M	
Abbreviation	**Definition**
MJL	Medial joint line
ML	Monthly letter
MTJ	Musculotendinous junction
MMT	Manual muscle test
MMT	Medial meniscus tear
MSK	Musculoskeletal
MWM	Mobilization with movement
Letter N	
Abbreviation	**Definition**
NMES	Neuromuscular electrical stimulation
NPS	Net Promoter Score
Letter O	
Abbreviation	**Definition**
O2	Oxygen
OA	Osteoarthritis
OASIS	Outcome and Assessment Information Set
OH	Over head
ORIF	Open reduction internal fixation
Letter P	
Abbreviation	**Definition**
PA	Posterior to anterior
PB	Physioballs
PD	Parkinson's disease
PER	Pronation-External Rotation
PFJ	Patellofemoral joint
PMHx	Past medical history
POC	Plan of care
PRN	As needed
PROM	Passive range of motion
PRP	Platelet-rich plasma
Pt	Patient
PVM	Paravertebral muscles
Letter R	
Abbreviation	**Definition**
RA	Rheumatoid arthritis
RC	Rotator cuff
RCR	Rotator cuff repair
RCT	Rotator cuff tear
RE	Re-evaluation of patient
RFMD	Return from MD

Letter R	
Abbreviation	**Definition**
ROM	Range of motion
ROT	Rotation
RTM	Remote therapeutic monitoring
RTMD	Return to MD
RTS	Return to sport
RTSA/RTSR	Reverse total shoulder arthroplasty/ replacement
RTW	Return to work
Letter I	
Abbreviation	**Definition**
SAD	Subacromial debridement
SB	Side bend
SC	Sternoclavicular joint
SER	Supination-External Rotation
SG	Side glide
SGIS	Side glide in standing
SI or SIJ	Sacroiliac joint
SKTC	Single knee to chest
S/L	Side lying
SLAP	Superior labrum anterior to posterior
SLJ	Sinding-Larsen-Johansson syndrome
SLS	Single limb support
SNAG	Sustained natural apophyseal glide
SOR	Suboccipital release
s/p	Status post
SpO2	Oxygen saturation as per pulse oximeter
STG	Short-term goal
STM	Soft tissue mobilization
Letter T	
Abbreviation	**Definition**
TA	Transverse abdominis
TB	Theraband
TC	Talocrural
TENS	Transcutaneous electrical stimulation
THA/THR	Total hip arthroplasty/replacement
TID/TIW	Three times a day/three times a week
TKA/TKR	Total knee arthroplasty/ replacement
TM	Treadmill
TMD	Temporomandibular disorder

Letter T	
Abbreviation	**Definition**
TMJ	Temporomandibular joint
TSA/TSR	Total shoulder arthroplasty/ replacement
TTP	Tender to palpation
TUG	Timed Up and Go gait test
Letter U	
Abbreviation	**Definition**
US	Ultrasound
UBE	Upper body ergomete
Letter V	
Abbreviation	**Definition**
VASTM	Vibration-assisted soft tissue mobilization
VOR	Vestibulo-ocular reflex
Letter X	
Abbreviation	**Definition**
XFM	Cross-friction massage

Terminology

The following are some essential terms and phrases that should be included in physical therapy documentation:

- **Adaptive equipment:** Tools or devices used to assist a patient in daily activities, enhancing independence and safety.
- **Balance assessment:** This involves evaluating a patient's ability to maintain stability in various positions and environments.
- **Coordination assessment:** This focuses on the ability to execute smooth and controlled movements, often tested through various physical tasks that involve hand-eye coordination and the integration of multiple body parts.
- **Discharge plan:** This outlines the patient's progress, goals achieved, and recommendations for continued care or self-management after completing physical therapy.
- **Endurance testing:** This evaluates how well a patient can sustain prolonged physical activity, typically assessed through exercises like walking or cycling for a set duration or distance.
- **Functional mobility**: This term describes a patient's ability to perform everyday activities such as walking, climbing stairs, or transferring from one position to another.
- **Gait:** The manner of walking or moving on foot, usually evaluated by a physical therapist to assess balance, coordination, and overall mobility.
- **Home exercise program:** A tailored set of exercises that patients can perform independently outside of therapy sessions to reinforce gains made during treatment and enhance recovery.

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- **Pain management techniques:** These are strategies implemented by physical therapists to help patients cope with pain during therapy sessions and in everyday life.
- **Pain scale:** A tool used to quantify a patient's pain levels, often ranging from 0 (no pain) to 10 (worst pain imaginable).
- **Patient goals:** These are specific, measurable objectives set collaboratively by the physical therapist and the patient to guide the rehabilitation process.

Type of documentation

There are various types of physical therapy documentation that therapists need to complete regularly. Some of these include:

- **Initial evaluation:** This is the first documentation a therapist completes when beginning treatment for a new patient. It includes information on the patient's medical history, current condition, and goals.
- **Progress notes:** These are used to track the patient's progress throughout their treatment.
- **Discharge summary:** This document outlines the patient's final status at discharge, including any improvements made and future recommendations.
- **Re-evaluation:** This is completed periodically to assess the patient's progress and make any necessary changes to their treatment plan.
- **Daily notes:** These are brief notes taken after each session, including the date, time, duration of treatment, and any significant findings or changes in the patient's status.

Tips for effective documentation

Here are some tips for effective PT documentation:

1. **Be specific:** Use specific terminology and descriptions in your documentation. Avoid general statements like "patient improved" and instead be more detailed by stating how they improved (e.g., increased range of motion by 10 degrees).
2. **Use objective language:** It's important to remain unbiased in your documentation and use objective language. Avoid using subjective terms like "patient felt better" and instead use measurable data such as pain scale ratings or functional outcome measures.
3. **Include patient feedback:** Documenting the patient's perspective and feedback is essential in understanding their progress and treatment effectiveness. Be sure to include any input or concerns expressed by the patient during each session.
4. **Keep it concise:** While it's essential to document thoroughly, it's also crucial to keep your notes concise and to the point. Avoid lengthy paragraphs and instead use bullet points or short phrases.
5. **Be organized:** Establish a consistent format for your documentation to make it easier to follow and review. Use headings, subheadings, and numbering systems to keep your notes structured and organized.

Common documentation errors to avoid

Here are some common errors that should be avoided when documenting a patient's status:

1. **Lack of clarity:** Be mindful of your word choice and avoid using vague or ambiguous language. This can lead to confusion and misinterpretation by other healthcare professionals.
2. **Incomplete documentation:** It's important to document all relevant information, including the patient's progress, treatment plan, and any adverse reactions or concerns. Incomplete documentation can lead to gaps in care and potential legal issues.
3. **Copying and pasting:** While it may save time, copying and pasting information from previous sessions can result in inaccurate or outdated information being documented. Always ensure that your documentation is specific to the current session.
4. **Over-documentation:** It's important to document thoroughly but avoid including irrelevant or excessive information. Stick to the relevant and significant details for each session.
5. **Lack of confidentiality:** Always ensure that patient information is kept confidential and secure. Do not include any personal identifying information, such as social security numbers or home addresses, in your documentation.

Additional notes