

Physi-Cal

Record Keeping Advice and Templates

Organised record keeping conveys a professional image and promotes the therapist as a legitimate healthcare practitioner.

Computers in a treatment room?

Patients are used to seeing computers when they visit their doctor, dentist or physiotherapist. No longer considered taboo in the treatment room, on the contrary, computers are a very useful tool for documenting patient records. As with conventional note taking, care must be taken to be seen to be listening; full attention needs to be given to the person who is speaking. More detailed notes can be written whilst the patient is preparing for the treatment or between appointments.

The interactive consultation

The consultation is an essential part of the healing process. Patients appreciate the time and attention being paid to their problem. Physi-Cal is interactive and allows the patient to get involved in the documentation process. Rather than the therapist sitting there shuffling through paperwork and making unseen notes, the client can observe and openly collaborate in the procedure. The more patients understand and are involved the more comfortable they are likely to be with their treatment. Copies of the patients chart and treatment plan can easily be given or sent on to the patient if required.

Treatment Record Systems

A number of treatment record formats exist including SOAP and CARE notes. The system you use doesn't need to be an acronym, you can adapt or develop your own format but it should satisfy certain minimum requirements.

Why keep documentation?

- Provides an examination and treatment history for each session.
- Provides a record of contraindications and red flags.
- Demonstrates and monitors patient progress.
- Provides evidence to defend against a malpractice suit.
- Records are required for reimbursement from insurance companies.
- Records may need to be shared in the case of a referral.
- Keeping treatment records may be required by law or code of practice.
- Copies of treatment notes can be sent to patients.

Client intake form

First name

Surname

D.O.B

Address

Telephone

Mobile

Email

Doctor's Address

Occupation

Consent to examination and treatment

I understand the reasons for my examination and treatment and give my consent to these procedures being used by

..... (Therapist)

I understand that records of my treatment will be kept in accordance with the Data Protection Act 1998 (UK)

Name.....

Signature.....

Date.....

S.O.A.P Notes

Subjective, objective, assessment and plan

This is a common method of documentation used by health care professionals. It may be the advised method of documentation when dealing with insurance companies and will provide a familiar, consistent format when communicating with doctors and other health care workers.

- Subjective: *The patient's condition in their own words.*

Onset/History

Location

Character of Pain (Sharp/Dull Ache)

Degree of Pain(1–10)

Alleviating/Aggravating factors

Temporal pattern(Worse in the morning)

Medical History(General health/Medication)

Social History(work/exercise)

- Objective: *Observation and testing*

Posture

ROM

Palpation

Special Tests

- Assessment: *Evaluate the information*

Summarise current status

List relevant problems

Post treatment assessment (changes)

Patient response

- Plan: *Address future treatments*

Exercises

Special care instructions/ advice

Referral?

Next appointment notes

C.A.R.E Notes

Condition of client, Action taken, Response of client, Evaluation

Another system of documentation used by therapists.

- Condition of Client

Subjective and objective assessment of client

Current condition

Areas of discomfort

Medical/ Family History

Emotional wellbeing

Observations (posture/ degree of movement)

Palpation

Degree of discomfort(1-10)

- Action taken: *Summary of treatment and techniques used during session*

- Response of Client: *Feedback from client*

Verbal response

Nonverbal response

- Evaluation: *An evaluation of the treatment and plans for future sessions*

Overall assessment of session

Advice/ suggestions given

Follow up session notes/ treatment plan