

# 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		Letter D	
Abbreviation	Definition	Abbreviation	Definition
AAROM	Active assisted range of motion	DA	Direct access
ABD	Abduction	DB	Dumbbell
AC	Acromioclavicular joint	DDD	Degenerative disc disease
ACDF	Anterior cervical discectomy and fusion	DFM	Degenerative joint disease
		DKTC	Double knee to chest
ADL	Activities of daily living	DLS	Double limb support
AFO	Ankle foot orthotic	DNF	Deep neck flexors
AKA	Above knee amputation	DPC	Digital patient care
AP	Anterior to posterior	Letter E	
APTA	American Physical Therapy Association	Abbreviation	Definition
		ECG or EKG	Electrocardiogram
AROM	Active range of motion	EDS	Ehlers-Danlos syndrome
Letter B		EIL	Extension in lying
Abbreviation	Definition	EIS	Extension in standing
BAPS	Biomechanical ankle platform system	EOB	Edge of bed
BFRT	Blood flow restriction training	EOS	End of session
BID/BIW	Twice a day/Twice a week	ER	External rotation
BKA	Below knee amputation	ES	Electrical stimulation
b/l	Bilateral	Letter F	
BOS	Base of support	Abbreviation	Definition
BOS	Beginning of session	FAI	Femoroacetabular impingement
BP	Blood pressure	FIL	Flexion in lying
BPPV	Benign paroxysmal positional vertigo	FMS	Functional movement screen
Letter C		FOB	Foot of bed
Abbreviation	Definition	FOM	Functional outcome measure
cc	Cable column	Letter G	
CCP	Cervical cold pack	Abbreviation	Definition
CEU	Continuing Education Unit	GH	Glenohumeral joint
CHP	Cervical hot pack	GIRD	Glenohumeral internal rotation deficit
CP	Cold pack	Letter H	
CPT	Current Procedural Terminology	Abbreviation	Definition
CVAD	Central venous access devices	HABD	Horizontal abduction
cx	Cancel	HADD	Horizontal adduction
CX or CS	Cervical spine	HBB	Hand behind back

Letter H		Letter M	
Abbreviation	Definition	Abbreviation	Definition
HBB	Hand behind back	MJL	Medial joint line
HEP	Home exercise program	ML	Monthly letter
HHA	Home Health Aide	MTJ	Musculotendinous junction
HHVBP	Home Health Value-Based Purchasing	MMT	Manual muscle test
		MMT	Medial meniscus tear
HOB	Head of bed	MSK	Musculoskeletal
HP	Hot pack	MWM	Mobilization with movement
HR	Heart rate	Letter N	
Hx	History of	Abbreviation	Definition
Letter I		NMES	Neuromuscular electrical stimulation
Abbreviation	Definition	NPS	Net Promoter Score
IASTM	Instrument-assisted soft tissue mobilization	Letter O	
		Abbreviation	Definition
IM	Intramuscular	O2	Oxygen
IM	Intramedullary	OA	Osteoarthritis
IPC	Intermittent pneumatic compression	OASIS	Outcome and Assessment Information Set
IR	Internal rotation	OH	Over head
IV	Intravenous	ORIF	Open reduction internal fixation
Letter J		Letter P	
Abbreviation	Definition	Abbreviation	Definition
JAMAR	Hand/grip dynamometer	PA	Posterior to anterior
Letter K		PB	Physioballs
Abbreviation	Definition	PD	Parkinson's disease
KTC	Knee to chest	PER	Pronation-External Rotation
Letter J		PFJ	Patellofemoral joint
Abbreviation	Definition	PMHx	Past medical history
LCP	Large cold pack	POC	Plan of care
LHP	Large hot pack	PRN	As needed
LJL	Lateral joint line	PROM	Passive range of motion
LMS	Learning management system	PRP	Platelet-rich plasma
LOB	Loss of balance	Pt	Patient
LOC	Loss of consciousness	PVM	Paravertebral muscles
LOS	Length of stay	Letter R	
LS or LX	Lumbar spine	Abbreviation	Definition
LTG	Long-term goal	RA	Rheumatoid arthritis
LTR	Lateral trunk rotation	RC	Rotator cuff
Letter M		RCR	Rotator cuff repair
Abbreviation	Definition	RCT	Rotator cuff tear
MC	Medicare	RE	Re-evaluation of patient
MHP	Moist hot pack	RFMD	Return from MD

Letter R		Letter T	
Abbreviation	Definition	Abbreviation	Definition
ROM	Range of motion	TMJ	Temporomandibular joint
ROT	Rotation	TSA/TSR	Total shoulder arthroplasty/ replacement
RTM	Remote therapeutic monitoring		
RTMD	Return to MD	TTP	Tender to palpation
RTS	Return to sport	TUG	Timed Up and Go gait test
RTSA/RTSR	Reverse total shoulder arthroplasty/ replacement	Letter U	
RTW	Return to work	Abbreviation	Definition
Letter I		US	Ultrasound
Abbreviation	Definition	UBE	Upper body ergomete
SAD	Subacromial debridement	Letter V	
SB	Side bend	Abbreviation	Definition
SC	Sternoclavicular joint	VASTM	Vibration-assisted soft tissue mobilization
SER	Supination-External Rotation	VOR	Vestibulo-ocular reflex
SG	Side glide	Letter X	
SGIS	Side glide in standing	Abbreviation	Definition
SI or SIJ	Sacroiliac joint	XFM	Cross-friction massage
SKTC	Single knee to chest	Terminology	
S/L	Side lying	<p>The following are some essential terms and phrases that should be included in physical therapy documentation:</p> <ul style="list-style-type: none"> <li>• <b>Adaptive equipment:</b> Tools or devices used to assist a patient in daily activities, enhancing independence and safety.</li> <li>• <b>Balance assessment:</b> This involves evaluating a patient's ability to maintain stability in various positions and environments.</li> <li>• <b>Coordination assessment:</b> 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.</li> <li>• <b>Discharge plan:</b> This outlines the patient's progress, goals achieved, and recommendations for continued care or self-management after completing physical therapy.</li> <li>• <b>Endurance testing:</b> 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.</li> <li>• <b>Functional mobility:</b> This term describes a patient's ability to perform everyday activities such as walking, climbing stairs, or transferring from one position to another.</li> <li>• <b>Gait:</b> The manner of walking or moving on foot, usually evaluated by a physical therapist to assess balance, coordination, and overall mobility.</li> <li>• <b>Home exercise program:</b> A tailored set of exercises that patients can perform independently outside of therapy sessions to reinforce gains made during treatment and enhance recovery.</li> </ul>	
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		Continue to next page	
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		

- **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