How to use the Patient Assessment Form

It is essential to explain to the youphysio that the Patient Assessment Forms should be carefully filled out during each session with each patient, and be kept as a document for tracking the progress.

The form is based on SOAP reporting system, where S stands for “subjective” (What the patient has told youphysio, what are the complaints, how she/he is feeling, whether there is any progress), O-“objective” (this includes Visual Analogue Scale for the pain measurement, which is presented at the top of the document with the graphic face images representing pain intensity-0-no pain, 10-unbearable pain. Additionally, in this section the youphysio should write down any other observations he has made regarding patients’ appearance, ADL performance etc), A-"assessment” (youphysio should describe the assessment he performed, the tests carried out and the subsequent findings), P-“treatment plan” (what kind of treatment was performed and is projected for the future).

During the first appointment, however, the youphysio should use the body chart to mark where exactly the complaint is and to make notes by the indicated area regarding the symptoms felt, observations made etc. Therefore, the first session does not have separate SOAP reporting structure, only the Assessment and VAS measurement and the Treatment given.

During the final session recording, at the bottom of the form, is it important to write down the outcome of the treatment- what are the reasons for termination of the treatment (Recovered, no improvement, worsened).

Each recording should be dated and signed.