

Physical Assessment Documentation Example

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Physical Assessment Documentation Example

Comprehensive Adult History and Physical (Sample Summative H&P by M2 Student) Chief Complaint: "I got lightheadedness and felt too weak to walk" Source and Setting: Patient reported in an in-patient setting on Day 2 of his hospitalization. History of Present Illness: Patient is a 48 year-old well-nourished Hispanic male with a 2-month history of Rheumatoid Arthritis and strong family ...

Comprehensive Adult History and Physical This sample ...

Assessment Examples: For over 60 Assessment examples, take a look at the post: Therapy Documentation Example Templates to Save Time. The patient

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demonstrated improved ability to reach overhead with 2# weight. Further strengthening of the serratus anterior should aid in the precise motion of the GHJ to avoid impingement.

Physical Therapy SOAP Note

Example (Therapy Daily Note)

CHARTING EXAMPLES FOR PHYSICAL ASSESSMENT SKIN, HAIR AND NAILS Skin pink, warm, dry and elastic. No lesions or excoriations noted. Old appendectomy scar right lower abdomen 4 inches long, thin, and white. Sprinkling of freckles noted across cheeks and nose. Hair brown, shoulder length, clean, shiny. Normal distribution of hair on scalp and perineum.

CHARTING EXAMPLES FOR PHYSICAL ASSESSMENT | The Other Side ...

Physical Assessment Integument. Skin: The client's skin is uniform in color, unblemished and no presence of any foul odor. He has a good skin turgor and

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skin's temperature is within normal limit.
Hair: The hair of the client is thick, silky hair is evenly distributed and has a variable amount of body hair. There are also no signs of infection and infestation observed.

Complete Head-to-Toe Physical Assessment Cheat Sheet ...

Nursing assessment is the gathering of information about a patient's physiological, psychological, sociological, and spiritual status by a licensed Registered Nurse. Nursing assessment is the first step in the nursing process. A section of the nursing assessment may be delegated to certified nurses aides. Vitals and EKG's may be delegated to certified nurses aides or nursing techs.

Nursing assessment - Wikipedia

Typically, a comprehensive assessment begins with documenting a patient's health history before starting a physical exam. According to AMN Healthcare

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Education Services , the health history includes: the patient's medical complaint, present state of health, past health record, current lifestyle, psychosocial status and family history.

What Is a Comprehensive Health Assessment? - EIU Online

Sample Pediatric History and Physical Exam Date and Time of H&P: 9/6/16, 15:00 Historian: The history was obtained from both the patient's mother and grandmother, who are both considered to be reliable historians. Chief complaint: "The rash in his diaper area is getting worse." History of Present Illness: Cortez is a 21-day-old African American male infant who presented

Sample Pediatric History and Physical Exam

The basic outline of a therapy note should follow the SOAP format: Subjective, Objective, Assessment, and Plan. Both occupational therapy and physical therapy soap notes should have

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the same basic format whether you are writing an evaluation, a daily note , a progress note or a discharge note.

Occupational and Physical Therapy Soap Note Example

Before even touching the infant, notice the following: color, posture/tone, activity, size, maturity, and quality of cry. This infant has a normal pink color, normal flexed posture and strength, good activity and responsiveness to the exam, relatively large size (over 9 pounds), physical findings consistent with term gestational age (skin, ears, etc), and a nice strong cry.

Newborn Exam | Newborn Nursery | Stanford Medicine

Sample Abnormal Exam Documentation . Similar to documentation for other body systems, the more specific you can be about where a respiratory abnormality lies, and the quality of the abnormality itself, the better. You may note, for example, abnormal lung sounds

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at the lung bases vs. the apex, or on the right vs. the left side of the chest.

Documenting a Respiratory Exam - Just the Basics | ThriveAP

- Keep printout of patient's goals readily visible in the front of the patient's chart.
- Use tables and flowcharts whenever possible (Case Example 12-5) for documenting both interventions and outcomes.
- When documenting tests and measures, focus on changes to patient's status.
- Use electronic documentation whenever possible. Even if your facility has not yet implemented a ...

Treatment Notes and Progress Notes Using a Modified SOAP ...

Chapter 8: Physical Examination of the Neck and Cervical Spine In general, the neck viscerally serves as a channel for vital vessels and nerves, the trachea, esophagus, spinal cord, and as a site for lymph and endocrine glands.

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