The Orthopedic Group Physical Therapy - St. Clair
1145 Bower Hill Rd Ste 305
Pittsburgh, PA 15243-1348
Phone: (412)276-2040
Fax: (412)276-2458

Physical Therapy Initial Examination

Patient Name: Clunk, Hannah
Date of Birth: 04/18/1999
Referring Physician(s): Ramirez Del-Toro, Jose MD
Visit No.: 1

Date of Initial Examination: 08/01/2018
Injury/Onset/Change of Status Date: 04/01/2018
Diagnosis: ICD10: M25.511: Pain in right shoulder
Treatment Diagnosis: ICD10: M25.511: Pain in right shoulder

Subjective

History of Present Condition/Mechanism of Injury: In april shoulder began to tighten and a deep discomfort. Pitcher. Deep in sensation. Went to rehab appointment in June. band which didnt help. Real season end of Januray to the first week of May. pitcher only and some hitting and popping with swing
Primary Concern/Chief Complaint: reaching across or above the head
no tenderness
Pain Location: posterior deep pain
Pain Scale: Worst: 6 **Best:** 0 **Current:**
Pain Follow-up Plan: self mobilization and strengthening progression
Aggravating Factors: reaching lifting pitching
Home Health Care: No
Medical History: see edoc
Medical History Review: The patient has a history of present problem with a history of 1-2 personal factors and/or comorbidities that impact the plan of care.
Mental Status/Cognitive Function Appears Impaired? No
Current Medications: Other (see edoc)
Patient Goals: improve functional movement and return to pitching

Objective

Inspection

Inspection	significant R scapular winging and excessive protraction

Range of Motion

Comments
R shoulder ext 15deg
reach behind the back 2 inch diff
ER at N: 40deg
ER at 90 40deg
IR at 90 30deg with pain
shoulder flexion 100deg

Strength

Comments deferred scondary to significant ROM Limitations all planes

Palpation

Comments mild tenderness prox bicep and posterolateral shoulder

Assessment

Assessment/Diagnosis: patient presents with chief complaint of R shoulder ROM limitations and pain. She has limitation in all planes but most prominent in flexion and ER. Feels tightness with end range motion and occasional pinching. Emphasis on progression of ROM and muscular control as she progresses into deeper ranges
Patient Clinical Presentation: The clinical presentation is evolving with changing characteristics.

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Following the evaluation and extensive patient education regarding diagnosis, prognosis, and treatment goals, the patient (parent/guardian, power of attorney holder) actively participated in the creation of the current goals and agrees to the current treatment plan.

Rehab Potential: Good

Contraindications to Therapy: None

Short Term Goals:

1: (3 Weeks) | report 50% decrease in symptoms
2: (3 Weeks) | demonstrate shoulder flexion 150deg
3: (3 Weeks) | demonstrate symmetrical extension

Long Term Goals:

1: (6 Weeks) | report 80% reduction in symptoms
2: (6 Weeks) | demonstrate overhead holds 5lbs 30sec without symptoms
3: (6 Weeks) | demonstrate single arm plank symmetrical endurance
4: (6 Weeks) | demonstrate symmetrical ROw

Plan

Frequency: 2-3 times a week

Duration: 12 weeks

Plan: Begin Plan as Outlined

Treatment to be provided:

Procedures

Therapeutic Exercises, Neuromuscular Rehabilitation, Manual Therapy

Modalities

To Improve (Pain Relief, Decrease Inflammation, Increase Blood Flow, Improve Tissue Healing)

Certification of Medical Necessity: It will be understood that the treatment plan mentioned above is certified medically necessary by the documenting therapist and referring physician mentioned in this report. Unless the physician indicates otherwise through written correspondence with our office, all further referrals will act as certification of medical necessity on the treatment plan indicated above.

Thank you for this referral. If you have questions regarding this plan of care, please contact me at (412)276-2040.

Bradley Cipriani, PT
License #020212
Electronically Signed by Bradley Cipriani, PT on August 1, 2018 at 3:03 pm

Please sign and return: Fax#: (412)276-2458

I certify the need for these services furnished under this plan of treatment and while under my care.

__I have no revisions to the plan of care.
__Revise the plan of care as follows_____
_____

Physician Signature_____
J. Ramirez Del-Toro, MD

Date:_____