<table>
<thead>
<tr>
<th>Element</th>
<th>Who/When</th>
<th>Includes</th>
<th>Source of Information</th>
<th>Purpose</th>
</tr>
</thead>
</table>
| Examination   | Performed by the physical therapist on all patients prior to provision of interventions | • History  
• Systems review  
• Tests and measures | • Medical record review  
• Patient interview  
• Communication with others | Provides data needed for the physical therapist to determine the plan of care |
| Evaluation    | Performed by the physical therapist in conjunction with, and based upon, the examination | • Plan of care (goals and interventions to be provided)  
• Involvement of other providers | The clinical judgement of the physical therapist based upon findings from the examination | Allows others (including the physical therapist assistant) insight into the anticipated level of improvement, intervention plan, and frequency and duration of services |
| Diagnosis     | Determined by the physical therapist | A label which describes the dysfunction requiring physical therapist interventions | | |
| Prognosis     | Determined by the physical therapist | The predicted level of improvement, treatment goals, expected outcomes, duration and frequency of treatment and interventions to be used | | |
| Intervention  | Done by the physical therapist or physical therapist assistant (as directed) to produce the changes in the patient’s condition | • Patient or client instruction  
• Airway clearance techniques  
• Assistive technology  
• Biophysical agents  
• Functional training in self-care and domestic, work, community, social, and civic life  
• Integumentary repair and protection techniques  
• Manual therapy techniques  
• Motor function | Specific interventions to be provided per the categories outlined by the physical therapist in the plan of care | Decrease inflammation, decrease pain, increase motion, improve functional abilities, etc |
| Outcomes      | Performed by the physical therapist or the physical therapist assistant | Tests and observations consistent with initial examination  
Initial examination and follow-up documentation | | Used to determine patient response to interventions and progress toward goals |