BREKKE REHAB CONSULTING

Documentation Assistance for New Grads

Documentation doesn't need to be perfect - It needs to be clear, defensible, and reflective of your clinical reasoning

Documentation is one of the big reasons new grads burnout in physical therapy.

This document is meant to support new grads with practical, confidence-building, and compliant documentation.

Documentation exists to:

Communicate clinical reasoning

Justify medical necessity

Track change over time

Protect the patient and the clinician

Aim for: clear, relevant, and defensible documentation. Another clinician should be able to see your patient tomorrow with minimal difficulties.

What Actually Matters

Eval Non-negotiables

- Why the patient is here now
- Baseline vs current function
- Key impairments tied to function
- Clinical reasoning behind your plan
- Why skilled PT is required

Would insurance understand WHY this patient is being treated

Daily Note - Non-negotiables

- What you did and why
- Patient response to what you did (objective or subjective)
- Any change from prior session
- Skilled decision-making or progression

Not required:

- Repeating the entire eval
- Novel wording every visit

Progress Note - Non-negotiables

- Change over time (even small)
- What improved vs what didn't
- Updated reasoning
- Justification to continue, modify or discharge

Re-evals can be done with significant change (worse or better), prolonged time between sessions, change in diagnosis or medical status, new red flags or unexpected findings.

Common pitfalls:

- Over-documenting
- Writing a textbook
- Copy-pasting without updated reasoning
- Not explicitly tying impairments to function

Example formula for notes:

Exam finding: impaired gaze stabilization with head turns

Functional impact: difficulty walking in busy environments

Skilled decision: Progressed VOR exercises to dynamic standing to target task-specific deficits

Time-Saving Strategies
• Templates that are easy to edit with clinical reasoning • “smart phrases” that still allow personalization • Writing notes immediately after session • One sentence per section rule
Documentation Language
• Requires skilled cues to _____ • Progression limited by _____ • Patient demonstrates improved carryover with ____
What To Do When Unsure
• Document uncertainty honestly but confidently • Ask a mentor and reflect changes next session • Avoid retroactive charting fixes unless instructed