College of Physiotherapists of New Brunswick / Collège des physiothérapeutes du Nouveau-Brunswick

CLINICAL REASONING: CASE HISTORY

INTRODUCTION:

As part of your application for full licensure with CPTNB, you are being asked by the Registration Committee to complete a clinical case history. You may reference any patient you have treated in your time as a provisional physiotherapist, but this must reflect your own experience only.

In short, you are to provide a detailed clinical presentation of a client requiring physiotherapy services and explain your rationale for each question.

It is up to you to decide on the overall acuteness/irritability of the condition, and your decision should be reflected in the planning and justification of the assessment and treatment techniques.

If you use abbreviations, provide the full word first and indicate in brackets the abbreviation you will continue to use.

Be clear and concise. If you are asked to list three findings, list only three findings. Again, provide your rationale at each step of the case history.

QUESTIONS:

A. Indicate the reason this person requires physiotherapy.

B. Describe the clinical history as provided by the patient (subjective). Include all aspects of the interview such as- but not limited to- past medical history, history of present illness, social, occupational, medications, known test results, etc.

C. Describe any precautions and/or contraindications you would need to be aware of before providing physiotherapy to this client.

D. Indicate how you have acquired “informed consent” to provide physiotherapy intervention. What factors should you consider with a client who is not of legal age and fully intact cognitively?

E. List three (3) patient-identified problems and the related structures and systems that may be involved for each problem. This could include perceived impairment/functional limitations involving environment, social, leisure or occupation, for example.
State your rationale for choosing these three structures and/or systems.

F. List three (3) questions you have asked to establish acuity/irritability of the situation. Describe your determination of acuity/irritability and indicate how this determination will direct your objective exam.

G. Write two (2) questions that would help to identify any psychosocial, occupational, or prognostic (issues affecting goals/outcomes) flags. Explain why you would ask these questions.

H. Consider the need to involve other team members or request other medical diagnostic tests and include rationale for these considerations.

I. Present a detailed description of at least four (4), and not more than eight (8), objective measurements you would perform during your objective exam. Provide justification for each.

J. Considering the subjective and objective findings, develop two (2) possible clinical diagnoses, if appropriate. Justify the clinical diagnoses by reviewing the tests performed, the results of those tests and your clinical conclusions. If you developed two clinical diagnoses, explain your final decision based on the subjective/objective findings. List at least three (3) reasons for each, with the rationale to support each decision.

K. Develop a list of at least four (4) problems based on the subjective/objective findings and explain the rationale for choosing these four problems.

L. Develop a detailed treatment plan for each of the problems, including the intervention rationale.

M. Provide an article to support one of your treatment interventions and briefly describe the evidence it provides. (The article itself may be attached as a separate document.)

N. Establish physio- and patient-stated goals for each problem. Indicate the objective outcome measures used to determine goal achievement. Documentation should reflect goals that are mutually established and provide timelines with rationale.

O. Describe in detail two (2) return appointments/visits. Include treatment goals, testing criteria and progression anticipated from one visit to the next. Describe changes in

treatment course if the patient were to have an adverse reaction to the previous treatment provided.

P. Include in the detail of the return appointments information under the following headings:
   1. Education with Rationale
   2. Hands-on with Rationale
   3. Exercise with Rationale
   4. Other (home exercise programs, pain managements strategies, use of support personnel, etc.) with Rationale

Q. Outline in detail your progression to discharge, addressing the identified problems and goals. Include barriers that may occur to reaching goals.

R. At discharge, discuss client expectations re mutually established goals and discuss any further follow up that may need to occur. Include consideration of other services that may be appropriate at the time of discharge.