THERAPY DAILY NOTE

Name:	ID:	Diagnosis:	Date

SUBJECTIVE:

PAIN LEVEL

OBJECTIVE

TREATMENT

BILLING (Document unit count for each)

____Manual Therapy ____Therapeutic Exercises ____Therapeutic Activities ____Neuromuscular Re-Education	____Community/Work Reintergration-Training ____Body Mechanics/Postural Training-Education ____Self-Care/ADLs /Home Management Training ____Gait Training ____Ultrasound	___ ________ ___ ________ ___ ________

ASSESSMENT

PLAN

____
Therapist Signature

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