ONSITE PHYSIO

THERAPY DISCHARGE SUMMARY

Name:	ID:	Diagnosis	Date
Job Title	**Employer**	**Work Status**	**Surgery Date**

SUBJECTIVE:

PAIN LEVEL CURRENT WORST BEST	
EVALUATION DATE:	NUMBER OF TREATMENT SESSIONS:

OBJECTIVE

ROM and Strength

Motion/Muscle						
AROM						
PROM						
MMT/Strength						

OTHER OBJECTIVE FINDINGS:	TREATMENT

BILLING (Document unit count for each)

___Manual Therapy	___Community/Work Reintergration-Training	___ _____
___Therapeutic Exercises	___Body Mechanics/Postural Training-Education	___ _____
___Therapeutic Activities	___Self-Care/ADLs /Home Management Training	___ _____
___Neuromuscular Re-Education	___Gait Training	
	___Ultrasound	

☐ **NO CHARGE/No VISIT (DISCHARGE SUMMARY ONLY)**

Summary of Progress

HEP Compliance **Treatment Compliance**

Discharge Reason/Plan

_____ **Therapist Signature**

_____ **Physician Signature and Date**

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