ONSITE PHYSIO

THERAPY PROGRESS 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 what was done 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	____ _____ ____ _____ ____ _____

☐ **NO CHARGE/NO VISIT (PROGRESS SUMMARY ONLY)**

Summary of Progress

HEP Compliance **Treatment Compliance**

Plan

Therapist Signature

Physician Signature and Date

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