ONSITE PHYSIO

PHYSICAL THERAPY DAILY NOTE

Name:	ID:	Diagnosis	Date

SUBJECTIVE:

PAIN LEVEL

OBJECTIVE	TREATMENT

BILLING

Manual Therapy	Body Mechanics Training / Education	_____
Therapeutic Exercises	Postural Training / Education	_____
Therapeutic Activities	Gait Training	_____
Neuromuscular Re-Education	Ultrasound	_____
Home Exercise Program Instruction		

ASSESSMENT

PLAN

_____

Therapist Signature

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