PHYSICAL 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

- [ ] Manual Therapy
- [ ] Therapeutic Exercises
- [ ] Therapeutic Activities
- [ ] Neuromuscular Re-Education
- [ ] Home Exercise Program Instruction
- [ ] Body Mechanics Training / Education
- [ ] Postural Training / 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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