



PHYSICAL 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/Strength						
AROM						
PROM						
MMT/Strength						

OTHER OBJECTIVE FINDINGS:	TREATMENT
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BILLING

<input type="checkbox"/> Manual Therapy <input type="checkbox"/> Therapeutic Exercises <input type="checkbox"/> Therapeutic Activities <input type="checkbox"/> Neuromuscular Re-Education <input type="checkbox"/> Home Exercise Program Instruction	<input type="checkbox"/> Body Mechanics Training / Education <input type="checkbox"/> Postural Training / Education <input type="checkbox"/> Gait Training <input type="checkbox"/> Ultrasound	<input type="checkbox"/> NO CHARGE/ NO VISIT (PROGRESS SUMMARY ONLY) <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
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Summary of Progress

HEP Compliance Treatment Compliance

Plan