Physical Therapy/Occupational Therapy Note

Patient's last Name	First Name	Patient Number	Date of Service

Time		
In	Out	Min
AM PM	AM PM	

pt signature

Exercises: ☐ Passive ☐ Active ☐ Active Assistance ☐ Resistive

Performed With: ☐ R.U.E. ☐ L.U.E. ☐ Trunk ☐ R.L.E. ☐ L.L.E. ☐ Neck

Transfer Activities: ☐ Hoyer Lift. ☐ Crutches ☐ Walker ☐ W/C ☐ Cane ☐ Quad Cane Other____________

Instructed: ☐ Patient ☐ Significant Other ☐ Family

Gait Training: ☐ N.W.B. ☐ P.W.B. ☐ F.W.B. ☐ Even Surfaces ☐ Stairs ☐ Uneven Surfaces

Assistance Required: ☐ Maximum ☐ Minimum ☐ Moderate ☐ Guarding ☐ Other______

Distance Ambulation: ☐ 20 ft. ☐ 40 ft. ☐ 60 ft. ☐ 80 ft. ☐ 100 ft. ☐ 120 ft.

Instruction of Home Program: ☐ Patient ☐ Significant Other ☐ Family

Level of Understanding: ☐ Unable to repeat instructions ☐ Needs further teaching ☐ May repeat instructions

---

Supervisory Visit:

Patient Satisfied with Care	☐ Yes	☐ No
Aide Following Care Plan	☐ Yes	☐ No
Care Plan Update	☐ Yes	☐ No

Narrative:____

____

____

____

____

Progress Toward Goals: ____

____

____

Therapists Signature:____________________________