Professional Nursing Service

THERAPY TREATMENT PROGRESS NOTE ☐PT ☐OT ☐ST

Payor Source _____ UHHC# _____ Patient Identifiers: ☐ Facial Recognition ☐ Patient Address ☐ DOB Initial Visit

Patient Name _____ D.O.B. _____

CURRENT STATUS (Subjective, Objective, & Assessment) Frequency / Duration _____

Pain: □ None □ Improved □ Worse Location(s) _____

Duration_____ Intensity 0-10 _____ Relief Measures_____

SUPERVISION: ☐PTA ☐OTA ☐HHA ☐POC BEING FOLLOWED ☐POC REVISED ☐PATIENT SATISFIED WITH SERVICE

SKILLED SERVICES PROVIDED

	Home Exercise Program-Instruction/Progression		DME/Orthotics /Prosthetics Assessment/Training/Modification		Speech Exercises		Fine Motor Skills Training
	Motor Planning Activities		Positioning Activities		Language Exercises		Pre-Writing Training
	Strengthening Exercises		Balance/Coordination Ex/Training		Swallowing Training		ADL Training
	ROM/Stretching Exercises		Transfer Training		Oral Motor Exercises		Cognitive Skills Development
	Manual Techniques		Gait Training		Wheelchair Mobility Training		Sensory Motor Activities
	Neuro-Muscular Re-education		Postural Control Training		Environmental Mobility Training		
	Gross Motor Skills Training		Other:				

PLANS / RECOMMENDATIONS

☐ Continue:

☐ Change:

☐ Contact:

☐ Instruction:

NOTE TO PARENT/CAREGIVER:

Patient/Caregiver response to teaching:

Assistant Sign/Lic#:	Patient / Caregiver Signature X
Therapist Sign/Lic#:	

Visit Date: _____ Time In: _____ Time Out: _____