McLAREN FLINT
Flint, Michigan 48532

PHYSICAL THERAPY PROGRESS REPORT

Date: ______________________

REFERRING PHYSICIAN: ______________________ Phone: ______________ Fax: ______________

PRIMARY PHYSICIAN: ______________________ Phone: ______________ Fax: ______________

PATIENT: ______________________________ Date of Birth: ______________________________

DIAGNOSIS: ____

The patient attended therapy ______ Visits ______ No Shows ______ Cancellations with treatment consisting of:

1. ______________________________ 3. ______________________________

2. ______________________________ 4. ______________________________

OBJECTIVE PROGRESS:	IMPROVEMENT	REGRESSED	NO CHANGE	N/A	COMMENTS:
ROM	☐	☐	☐	☐	
STRENGTH	☐	☐	☐	☐	
PAIN	☐	☐	☐	☐	
ADL	☐	☐	☐	☐	
GAIT	☐	☐	☐	☐	

ASSESSMENT/CLINICAL IMPRESSION

____

____

____

____

____

____

____

____

PLAN/GOALS:

____

____

____

Therapist: ______________________________ Facility: ______________________________

Telephone: ______________________________ Fax Number: ______________________________

PHYSICAL THERAPY PROGRESS REPORT

MHCC-2855-A (9/14)

460b

PT.

MR.#/RM.

DR.