[COMPANY NAME]
Physical Therapy Outpatient Progress Report
Phone: (___)_____ - Fax: (___)_____

Patient: _____ **D.O.B.:** _____ **Date:** _____

Physician: _____ **Dx:** _____

Treatment Dates: From: _____ To: _____ #of Treatments: _____ #Missed: _____

Treatment Program: _____

_____

_____

_____

Objective measurements from initial visit/present condition: _____

_____

_____

_____

Response to treatment: _____

_____

_____

Therapist's Recommendations:
[ ] Continue therapy for _____ weeks for _____.
[ ] Discontinue therapy secondary to patient met all goals.

Recommendation for future care or changes in treatment program:

_____

_____

Thank you for this referral!

_____
Physical Therapist's Signature

Physician's Recommendations:

[ ] Continue present treatment program for _____ weeks.
[ ] Continue present treatment program with the following recommended changes:

_____

_____

[ ] Discontinue therapy.

_____ _____
Physician's Signature Date

Revised:_____