[COMPANY NAME]

Address: _____
Phone: (___)_____ Fax: (___)_____

PHYSICAL THERAPY OP DISCHARGE REPORT

NAME: _____ **D.O.B.:** _____
DATE: _____
PHYSICIAN: _____
DIAGNOSIS: _____
TREATMENT DATES: **FROM:** _____ **TO:** _____
SESSIONS ATTENDED: _____ **MISSED:** _____

Symptomatology Identified on Initial Visit: _____

_____

_____

Treatment Administered: _____

_____

_____

Pain Rate: _____

Strength: _____

ROM: _____

Gait: _____

Balance/Coordination: _____

_____

Achievement of Goals: _____

_____

_____

_____

Recommended Home Program: _____

Prognosis: _____

_____

_____
Physical Therapist Signature:

_____
Physical Therapist's Assistant Signature: