☐ Progress Note ☐ Discharge Summary

Date: _____ Treatment Time: _____ to _____

Clinic Address
Clinic City, State Zip Code
Clinic Phone Number | Fax Number

Patient Name: _____
DOB: _____ Patient Number: _____

Referring Physician: _____ Medical Diagnosis: _____

Subjective: Pain/Location ___/10: _____
_____
_____
_____

Attendance: Number of Treatments: _____ Cancellations: _____ No Shows:_____

Treatment Included: _____

Objective Findings: _____
_____
_____

Functional Improvements / Limitations:_____
_____

	ROM		Strength	

Education: ☐ Patient is independent with basic / advanced Home Exercise Program
☐ Patient requires further HEP

Assessment & Goal Status: _____
_____
_____
_____

Plan: ☐ Discharge from AT ☐ **Continue AT** _____ **times per week for** _____ **weeks**
_____
_____

Athletic Trainer Signature: _____ Date: _____

Physician Signature: _____ **Date:** _____

Please sign and fax to: (222-222-2222)