



FUNCTIONAL PROGRESS CHART

Member:
 Diagnosis:
 Referring Physician:
 Therapy Office:
 Treating Clinician:
 Discipline: PT / OT
 Involved Side: Left / Right / N/A

Member ID #:
 Insurance Company:
 Referring Physician ID#:
 Date of Birth / Age:
 ICD-9 (s):
 Diagnosis:
 Date of Injury: ____ / ____ / ____
 Date of Surgery: ____ / ____ / ____

- Clinical Update
- Additional Visits Request

Number of Additional Visits Requested: _____

	Date:	Date:
Total Number of Visits To Date		
Pain Scale /10		
Gait		
AROM		
Strength		
Proprioceptive/ Neurological Deficits		
Functional Limitations / Additional Comments		