

Functional progress chart

Clinical update Additional visits request

Member name:	Member ID:
Medical/therapy diagnosis:	
Referring physician:	Referring physician ID:
Therapy office:	Discipline: <input type="checkbox"/> Physical therapy <input type="checkbox"/> Occupational therapy
Member date of birth/age:	Involved side: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> N/A
ICD-10(s):	
Date of injury:	Date of surgery:

	Dates of service:
Total number of visits to date/ time period covered	
Pain scale of 0-10	
AROM	
Percentage restored to baseline or percentage of unaffected contralateral extremity	
Strength scale of 0-5 or grade on manual muscle testing	
Function limitations/additional comments	
Functional progress	
Goals	
Changes in prognosis/plan of care/goals (if applicable)	

Signature of qualified professional

Title

Date