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PHYSIOTHERAPY PROGRESS REPORT

Client _____
 Treatment Facility _____
 Referring Physician _____
 Date of Referral _____
 Date of Initial Authorization _____
 # of Treatments To Date _____
 Report Date _____

Claim No _____
 Therapist _____
 Case Manager _____
 Date of Initial Assessment _____
 # Missed appointments / Cancellations _____

SUBJECTIVE	<u>Symptoms</u>
OBJECTIVE SPECIFIC	<u>Posture/Observations</u>
	<u>Neurological Status</u>
	<u>ROM</u>
	<u>Muscle Testing</u>
	<u>Stability Testing</u>
	<u>Relevant Special Tests</u>
	<u>Palpation</u>

Client _____

Claim No _____

ANALYSIS

Problem List

Clinical Impression

Progress Towards Previous Functional Goals

Functional Goals

Barriers to Rehab

RTW Comments

CURRENT TREATMENT PLAN

Electrophysical Agents

- | | | | | | |
|------------------------------|---------------------------------------|------------------------------|---------------------------------------|----------------------------------------|--------------------------------------|
| <input type="checkbox"/> US | <input type="checkbox"/> Hot Pack/Ice | <input type="checkbox"/> IFC | <input type="checkbox"/> TENS | <input type="checkbox"/> Traction | <input type="checkbox"/> Laser |
| <input type="checkbox"/> WPB | <input type="checkbox"/> EMS | <input type="checkbox"/> WAX | <input type="checkbox"/> Microcurrent | <input type="checkbox"/> Iontophoresis | <input type="checkbox"/> Acupuncture |

Manual Techniques

Education

Exercise

ROM/Flexibility

Specific Strengthening

General Strengthening/ Aerobic Conditioning

Home Program

Comments/Recommendations

Discharge Date _____

Discharge Disposition _____

Signature _____

Date _____

PLEASE FORWARD TO WORKSAFENB - P.O. Box 160, Saint John (New Brunswick) E2L 3X9 **OR** FAX TO: 1-888-629-4722.

Section 41(10) of the Workers' Compensation Act authorizes you to release this information.
This document may be examined by any person with a direct interest in a claim that is under review.