

Carelink Health Care Services, LLC

PHYSICAL THERAPY VISIT NOTE

Patient Name: _____

M/R # _____

Vital Signs	Behavior/Mental Status	Homebound:	Interventions:	Pain	
T: _____	☐ Alert/Oriented	Yes ☐ No ☐	☐ Therapeutic Exercise	Frequency: ☐ No Pain	
P: _____	☐ Anxious	☐ Ambulation	☐ Patient/CG ED.	☐ Less than daily	
R: _____	☐ Motivated	☐ Endurance	☐ Transfer Training	☐ Daily but not constant	
B/P: _____	☐ Lethargic	☐ Strength	☐ H.E.P.	☐ All the time	
Wt: _____	☐ Apathetic	☐ Balance	☐ Gait Training	Pain Profile: ☐ Site: _____	
	☐ Noncompliant	☐ R.O.M.	☐ Balance Training	0 1 2 3 4 5 6 7 8 9 10	
	☐ Comatose	☐ Bed/WC Bound	☐ Functional Mobility	Current Pain Management and effect:	
	☐ Other	☐ Respiratory/S.O.B.	☐ Modalities		
		☐ Fall Risk	☐ Endurance Training		

Subjective: _____

Objective: _____

Teaching

Please circle all that apply below								
Teaching Tool Used:	Written	Verbal	Demo	Handout	given to:	Patient	Caregiver	Both
	☐	☐	☐	☐		☐	☐	☐
	☐ Pt/Cg. Verbal understanding		☐ Pt/Cg. Return Demo					
Home Exercise Program follow through between therapy visits:					☐ adequate	☐ Inadequate	☐ N/A	

Assessment (progress toward goals): _____

Conferenced with:	SN	PT	OT	MSW	CAREGIVER	FAMILY
Regarding:	_____					

Plan: _____						

Discharge Planning Discussed: _____						
5 Day discharge notice given: ☐ yes ☐ no						

Therapist Name: _____ Title: _____ Date: _____

Please Print

Therapist Signature: _____ Time In: _____ Time Out: _____ Minutes: _____

Patient Signature: _____ MILES: _____