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Functional progress chart

☐ Clinical update ☐ Additional visits request

Member name:	Member ID:
Medical/therapy diagnosis:	
Referring physician:	Referring physician ID:
Therapy office:	Discipline: ☐ Physical therapy ☐Occupational therapy
Member date of birth/age:	Involved side: ☐ Left ☐ Right ☐ 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