

**Home Care
Physical Therapy Progress Note**

Time In: _____ Time Out: _____ Visit Date: _____

Agency: _____ Patient Signature: _____

Patient Name: _____ Homebound Status: _____

Subjective:

Objective:

Mental Status: ☐ Oriented ☐ Forgetful ☐ Disoriented ☐ Agitated ☐ Comatose ☐ Depressed ☐ Lethargic

Therapeutic Exercise:

Balance Training:

Transfer Training:

Deviations/ Correction:

Bed Mobility Training:

Deviations/Correction:

Gait Training/Wheelchair Mobility Training

Pain:

Other:

Instructions: ☐ Patient ☐ Caregiver ☐ Patient/Caregiver On ☐ Safety ☐ Proper Positioning
☐ Deep Breathing ☐ Proper Modality Use
☐ HEP ☐ Postural corrections

Outcome/Progression toward goal: _____

Plan: _____

D/C plans discussed with: ☐ Patient ☐ Caregiver ☐ Physician ☐ Other _____

Reported: _____

Care Coordination: ☐ PT ☐ ST ☐ HHA ☐ MSW ☐ OT ☐ SN ☐ Other _____

LPTA/Aide supervision (complete if applicable): ☐ Introduction ☐ Supervision LPTA/Aide present ☐ Yes ☐ No

LPTA/Aide following plan: ☐ Yes ☐ No (explain): _____

HHA care plan: ☐ Reviewed ☐ Revised/updated: _____

Next supervisory visit: _____ Next Physical Therapy Visit: _____

Therapist Signature/Title: _____