

Physical Therapy Daily Notes

Student's Name: _____ **Date of Birth:** _____

School: _____ **Therapist:** _____

Date of Service: _____

____ Direct Treatment ____ Consultation

____ Individual ____ Group

Treatment Provided:

	Gait Training		Professional Training		Wheel Chair Management
	Transfer Training		Positioning		Coordination
	Stair Climbing		Motor Planning		Adaptive Equipment
	Range of Motion		Strengthening		Therapeutic Handling
	Functional Skills		Balance		Gross Motor Skills
	Other				

Outcome:

Signature of PT/PTA,

Date

Signature of Supervising PT