Regional Medical Group

SANDY SPRINGS
Fax 404-943-9975 Phone 404-943-9996
5335 Roswell Road NE, Atlanta, GA 30342

DAILY TREATMENT NOTES

Patient's Name _____Visit #_____Date_____

Date this episode began_____

COMPLAINTS/CONDITIONS BEING TREATED WITH ACCOMPANYING FUNCTIONAL GOAL

#1 Complaint _____ #3 Complaint_____
Goal_____ Goal_____

#2 Complaint _____ #4 Complaint_____
Goal_____ Goal_____

TREATMENT PLAN: (Assume 15 min. unless noted for time codes)

☐ CMT_____ Technique Used_____ ☐ CMT-EXT_____ ☐ Hot/Cold_____ ☐ EMS_____ ☐ U/S_____ ☐ Traction_____
☐ Manual Therapy_____ ☐ Massage_____ ☐ Therapeutic Exercises_____ ☐ Other_____

#1 COMPLAINT - PATIENT STATED:

S ☐ Pain ☐ Stiffness ☐ Paresthesia ☐ Spasm ☐ L ☐ R ☐ Min ☐ Mild ☐ Mod ☐ Severe ☐ Intermittent ☐ Frequent ☐ Constant
☐ Other_____

O ☐ Decreased ROM ☐ No ☐ Yes_____ ☐ Edema ☐ No ☐ Yes ☐ R ☐ L _____
Muscle Hypertonicity ☐ No ☐ C ☐ T ☐ L ☐ Upper ☐ Mid ☐ Lower ☐ R ☐ L ☐ Other_____

A ☐ Same ☐ Better ☐ Worse - Why? _____ Improved _____% Worse _____%
☐ Treatment effective ☐ Yes ☐ No Treatment w/o incident ☐ Yes ☐ No Treatment tolerated well ☐ Yes ☐ No

P ☐ All therapies per treatment plan unless noted here: _____

#2 COMPLAINT - PATIENT STATED:

S ☐ Pain ☐ Stiffness ☐ Paresthesia ☐ Spasm ☐ L ☐ R ☐ Min ☐ Mild ☐ Mod ☐ Severe ☐ Intermittent ☐ Frequent ☐ Constant
☐ Other_____

O ☐ Decreased ROM ☐ No ☐ Yes_____ ☐ Edema ☐ No ☐ Yes ☐ R ☐ L _____
Muscle Hypertonicity ☐ No ☐ C ☐ T ☐ L ☐ Upper ☐ Mid ☐ Lower ☐ R ☐ L ☐ Other_____

A ☐ Same ☐ Better ☐ Worse - Why? _____ Improved _____% Worse _____%
☐ Treatment effective ☐ Yes ☐ No Treatment w/o incident ☐ Yes ☐ No Treatment tolerated well ☐ Yes ☐ No

P ☐ All therapies per treatment plan unless noted here: _____

#3 COMPLAINT - PATIENT STATED:

S ☐ Pain ☐ Stiffness ☐ Paresthesia ☐ Spasm ☐ L ☐ R ☐ Min ☐ Mild ☐ Mod ☐ Severe ☐ Intermittent ☐ Frequent ☐ Constant
☐ Other_____

O ☐ Decreased ROM ☐ No ☐ Yes_____ ☐ Edema ☐ No ☐ Yes ☐ R ☐ L _____
Muscle Hypertonicity ☐ No ☐ C ☐ T ☐ L ☐ Upper ☐ Mid ☐ Lower ☐ R ☐ L ☐ Other_____

A ☐ Same ☐ Better ☐ Worse - Why? _____ Improved _____% Worse _____%
☐ Treatment effective ☐ Yes ☐ No Treatment w/o incident ☐ Yes ☐ No Treatment tolerated well ☐ Yes ☐ No

P ☐ All therapies per treatment plan unless noted here: _____

#4 COMPLAINT - PATIENT STATED:

S ☐ Pain ☐ Stiffness ☐ Paresthesia ☐ Spasm ☐ L ☐ R ☐ Min ☐ Mild ☐ Mod ☐ Severe ☐ Intermittent ☐ Frequent ☐ Constant
☐ Other_____

O ☐ Decreased ROM ☐ No ☐ Yes_____ ☐ Edema ☐ No ☐ Yes ☐ R ☐ L _____
Muscle Hypertonicity ☐ No ☐ C ☐ T ☐ L ☐ Upper ☐ Mid ☐ Lower ☐ R ☐ L ☐ Other_____

A ☐ Same ☐ Better ☐ Worse - Why? _____ Improved _____% Worse _____%
☐ Treatment effective ☐ Yes ☐ No Treatment w/o incident ☐ Yes ☐ No Treatment tolerated well ☐ Yes ☐ No

P ☐ All therapies per treatment plan unless noted here: _____

Treatment Frequency and Duration: 2 3 times a week for 2 3 4 weeks Re-evaluation Date _____

Patient (sign and date) _____

Therapist _____ Doctor_____