

# Status Report

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Patient: \_\_\_\_\_ Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Initial Visit Date: \_\_\_\_\_ Last Visit: \_\_\_\_\_ Total Visits: \_\_\_\_\_

Treatment Consisted of: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Recommend:            \_\_\_\_\_ Continue Treatment            \_\_\_\_\_ Patient Progressing  
                              \_\_\_\_\_ Refer to Physical Therapy            \_\_\_\_\_ No Progress  
                              \_\_\_\_\_ Discharge    \_\_\_\_\_ Clarification of Prescribed Treatment

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_, L.M.P.

Physician:  
*Please complete the following and return the white copy to our office if further treatment is requested.*

**Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**1 2 3** days per week for \_\_\_\_\_ weeks.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_