

PROGRESS NOTE FOR PHYSIOTHERAPY/CHIROPRACTIC/ACUPUNCTURE

(All sections must be completed)

SECTION A – PARTICULARS OF THE PATIENT

Name of Patient: _____ Sex: _____

Date of Birth (day/month/year): _____ Member No.: _____ Policy No.: _____

If group insurance, name of the Policyholder: _____

SECTION B – PROGRESS NOTE CONFIRMED BY THE ATTENDING PHYSICIAN (AP)

1. Diagnosis given:

2. Recommended treatment:

3. Does the patient need Physiotherapy/Chiropractic/Acupuncture treatment? If Yes, type of treatment needed:

☐ Yes

☐ No

4. Number of required visits: _____

5. Result of the first treatment (1-10):

6. The reason why to order next treatment plan (11-20):

7. Result of the last treatment (11-20):

Name of Attending Physician (AP): _____

Address: _____

Telephone No.: _____

Signature of AP

E-mail: _____

Date (day/month/year): _____