THERAPY NOTE

Name: _____ DOB: _____ Date: _____

❑ **97140.** Manual therapy for at least 20 minutes to increase **pain**-free **range of motion** and facilitate a return to functional activities.

❑ **97110** Exercise therapy to improve mobility, stretching, **strength**, dexterity, coordination, **range of motion**, or endurance: Wobble chair _____min, Curve master _____min, Precor® stretching machine w/8 reps for _____min, Wall Track _____min. Modalities may vary per patient's ability. ❑ Wobble Board added to exercise therapy _____ min.

Total _____ min.

❑ **9921___.** Vital signs taken today by medical assistant. Disallow exercise therapy to continue if: Diastolic BP ≥100, Temperature ≥100.1 F, HR ≥ 100 bpm, Respirations ≥ 21 bpm. Bring abnormal vital signs to the medical provider on duty for a medical evaluation and permission, before exercise therapy can resume.

	Z13.83	Z13.6	Z01.30	
Temp F	Resp/Min	Pulse BPM	Blood Pressure	*(Record at least three vital signs)
_____	_____	_____	_____/_____	

❑ **97110 Exercises** were completed as prescribed, and were well tolerated: ❑ Yes ❑ No. If "No" explain:

Note: _____

Monitor's Printed Name _____ Signature_____ MA

❑ **97140 Manual Therapy** _____min. Technique utilized: ❑ Manual traction ❑ Lymphatic drainage.

Areas Treated: ❑ Cervical ❑ Thoracic ❑ Lumbar ❑ Pelvis ❑ Shoulder R L ❑ Arm R L ❑ Leg R L

Pain Scale: /10 /10 /10 /10 /10 /10 /10

Was completed as prescribed, and was well tolerated: ❑ Yes ❑ No. If "No" explain (below):

❑ Strapping of thorax, shoulder, elbow, wrist, hip, knee, lower leg, ankle, foot, and or toe area(s) to stabilize areas of sprains and strains, specified below:

Note: _____

Therapist's Printed Name _____ Signature_____ MA

Medical provider (**L2**: 1HPI + 1 Element + MDM $^{2 \text{ of } 3}$ or **L3**: (1-ROS + 1HPI) + 6 elements total + MDM $^{2 \text{ of } 3}$)

❑ See attached medical evaluation and or "Injection Therapy" documentation by provider.

❑ HPI(s): _____

❑ Condition Same or Improved (**Problem Points**-L2), or ❑ Condition Worse (**Problem Points**-L3).

❑ Dx of Muscle strain/myositis (**Low Risk**-L3) | **ROS**: Allergies: ❑ Unchanged ❑ New: _____

❑ Vitals | other ELEMENTS: ❑ Gait and station is symmetrical & balanced ❑ Respiration is diaphragmatic & even; accessory muscles not used ❑ Well developed, well nourished, NAD ❑ Conjunctiva clear, no lid lag &deformity ❑ External ears & nose w/out scars, lesions, or masses

❑ A determination was made that the patient should continue with Rx exercise therapy.

❑ Order: ❑ Strapping ❑ Estim ❑ Other: _____

Provider Printed Name _____ Signature_____ DO, MD, PA

*** A "Monthly Therapy Progress Note" is required EVERY month ***