Gunn High School
Physician Progress Note

Athlete's Name: _____ Date: ____/____/_____

(Check One) □ Initial Visit □ Follow-up Visit

Subjective: _____

_____

Objective: _____

_____

Assessment: _____

Treatment: _____ **Meds:** _____

Bracing /Crutches/Cast: □ Full Time □ Only During Activity

Settings: _____

Weight Bearing Status: □ None □ Partial □ As Tolerated □ Full

Areas of Improvement: _____

Rehabilitation/Participation Status: □ ROM Limits: Flex: _____ Ext: _____

Specific Activities

□ Yes □ No: _____ □ Yes □ No: _____

□ Yes □ No: _____ □ Yes □ No: _____

□ Yes □ No: _____ □ Yes □ No: _____

Practice Status: □ Full Go □ Limited □ Out Restrictions:_____

Competition Status: □ Full Go □ Limited □ Out Restrictions:_____

Weights Status: □ Full Go □ Limited □ Out Restrictions:_____

Specific Restriction: _____

_____

Follow-up Appointment: _____ Days / Weeks / Months

Physician's Name: _____

Physician's Signature: _____ Date: _____