



Beth Shelly PT
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Daily progress note Total treatment time _____ to _____

Name _____ Date _____

S: Incontinence – better, worse, same _____ x per day/ week
Voiding schedule / urgency/ frequency: better, worse, same _____ x per day

Other: _____

O: Pelvic floor muscle exercise (sensor type: vaginal, external, rectal)
____ Seconds hold, ____ seconds rest, ____ repetitions Rise – slow, fair, good
____ uV work Hold – poor, fair, good
____ uV rest Fall – slow, fair, good
Consistency
____ Seconds hold, ____ seconds rest, ____ repetitions work – poor, fair, good
____ uV work rest - poor, fair, good
____ uV rest Baseline – irreg, steady, elevated
____ Continued practice Accessory mm _____

Patient education / therapeutic activity:
Bladder training
____ Hours between voiding
____ Bladder training education
____ Fluid intake modifications:
Increase, decrease, avoid caffeine, avoid acid

Other education:

Therapeutic exercise:

Other:

A:

P:

Times code treatment minutes _____

Signature _____ Date _____

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