



PHYSICAL THERAPY SESSION NOTES

STUDENT NAME: _____ DATE OF BIRTH: _____

DISTRICT OF LIABILITY: _____

IEP GOALS / OBJECTIVE(S) - (EITHER WRITE OUT OR INDICATE WITH A SYMBOL): _____

Session Date: _____
Start Time: _____
Stop Time: _____
Total Minutes: _____
Circle One: (G) Group (I) Individual
** Evaluation Type: _____
(1) PPT Eval High Complex 45 min
(2) PPT Eval Med Complex 30 min
(3) PPT Eval Low Complex 20 min
(4) Reevaluation
Student Observations:
☐ Met session objectives
☐ Good effort demonstrated throughout session
☐ Limited progress due to: _____
☐ Other: _____
Related IEP Obj: _____
* Place of Service: _____
*** Rationale: _____

Description of Activities	
	Developmental
	Therapeutic Exercises
	Consultation
	Sensory Motor Activities
	Adaptive Equipment
	Mobility Training
	Assistive Technology
	Other:
	Other:

Provider Initial: _____

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* Place of Service Key: 1 = School, 2 = Home, 9 = Other

*** Rationale needed if exceed max time allowable

Unless so noted, school was in session and the student was in attendance on all days recorded. I have edited this form to correctly reflect the services delivered on the above dates.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____ CREDENTIAL: _____

SUPERVISOR'S SIGNATURE: _____ DATE: _____ CREDENTIAL: _____

I SUPERVISED THE ABOVE SLP AND/OR SLPA FOR THE DATES OF SERVICE INDICATED.