

Patients Name: _____

Date: _____

Diagnosis: _____

Precautions/Contraindications: _____

TREATMENT PROCEDURES

EVAL & TREAT

TREATMENT

- Active Range of Motion
- Passive Range of Motion
- Strengthening
- Home Exercise Program
- Joint Mobilization
- Myofascial Release
- Gait Training
- Neuromuscular Feedback
- Proprioceptive Training
- Postural Re-Education
- Body Mechanics Training
- Plyometric Training

MODALITIES

- Decompressive Spinal Therapy/Traction
- Laser Therapy
- Ultrasound
- Electrical Stimulation
- Hot Packs/Ice Packs
- Ionto / Phonophoresis
- TENS
- Massage
- Patellar Taping/Kenesiotaping
- Myofascial Release

SPECIALTY PROGRAMS

- Work Conditioning / Hardening
- Back School
- Pre-Op Program
- Job Site Analysis
- Home TENS Unit
- Home Traction Unit
- McKenzie Extension
- Post Surgical Rehab Protocol

GOALS

- Increase ROM
- Increase Strength
- Improve Function
- Increase Mobility
- Decrease Pain
- Decrease Edema
- Functional Training

TREATMENT FREQUENCY: Daily 3x/Wk 2x/Wk

TREATMENT DURATION: 1Wk 2Wks 3Wks 4Wks _____ Wks

ADDITIONAL COMMENTS: _____

I CERTIFY THE ABOVE SERVICES ARE BY THIS PATIENT ON AN OUTPATIENT BASIS.

PHYSICIAN SIGNATURE

MD / DO / PA / NP-C

LICENSE #: _____