

Patient Information

Name _____ Date _____

Diagnosis _____

Special Instructions/ Precautions _____

Frequency 3 Times
 2 Times
 1 Time

Duration 4 Weeks
 3 Weeks
 2 Weeks
 1 Week

Evaluate and Treatment

Therapeutic Exercise

- | | |
|--|--|
| <input type="checkbox"/> Core/ Trunk Stabilization | <input type="checkbox"/> Ergonomics Education |
| <input type="checkbox"/> Therapeutic Exercise/
Conditioning | <input type="checkbox"/> Post-Op Protocol |
| <input type="checkbox"/> Gait Training | <input type="checkbox"/> Balance Training |
| <input type="checkbox"/> Body Mechanics Education | <input type="checkbox"/> Home Exercise Program |

Manual Therapy

- | | |
|---|---|
| <input type="checkbox"/> Soft Tissue Mobilization | <input type="checkbox"/> Joint Mobilization |
| <input type="checkbox"/> Stretching | <input type="checkbox"/> Massage |
| <input type="checkbox"/> PROM | <input type="checkbox"/> Traction |
| <input type="checkbox"/> AROM | |

Modalities

- | | |
|---|--|
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Moist Heat/ Ice |
| <input type="checkbox"/> Home TENS Unit | <input type="checkbox"/> Iontophoresis |
| <input type="checkbox"/> Electrical Stimulation | |

Physician Signature _____