



Paradigm

Physical Therapy & Wellness
Science Applied Artfully

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NAME _____ DOB _____ DATE _____

Diagnosis _____ Patient Phone # _____

Narrative Rx (indications/precautions, weight bearing status, recent tests and X-ray results) _____

Frequency: ☐ Daily ☐ 2x/Week ☐ 3x/Week ☐ As Needed

Duration: ☐ 1 Week ☐ 2 Weeks ☐ 3 Weeks ☐ 4 Weeks

TREATMENT ORDERED:

- ☐ Evaluation
- ☐ Ambulation or Gait Training
- ☐ Home Exercise Program
- ☐ Injury Prevention
- ☐ Proper Lifting Technique & Body Mechanics
- ☐ Taping Techniques
- ☐ Joint Mobilization
- ☐ Fitness Program/Work Hardening
- ☐ Aquatic Therapy
- ☐ FCE
- ☐ Pelvic Floor Therapy

PHYSICAL THERAPY GOALS:

- ☐ Return to Work/A.D.L.'s
- ☐ Decrease Pain
- ☐ Decrease Edema
- ☐ Increase Function/A.D.L.
- ☐ Improve Posture
- ☐ Improve Balance/Decrease Risk of Falls
- ☐ Return to Normal Gait Pattern
- ☐ Increase Strength
- ☐ Increase R.O.M.
- ☐ Increase Endurance
- ☐ Decrease Spasm

REHAB POTENTIAL:

☐ Good ☐ Fair ☐ Poor

EXERCISE:

- ☐ Resistive (PRE's)
- ☐ Closed Chain Program
- ☐ Stabilization Program
 - ☐ Cervical
 - ☐ Lumbar
- ☐ Thoracic Range of Motion
- ☐ Active
- ☐ Passive
- ☐ Stretching Program
- ☐ Work Hardening
- ☐ Balance Activities
- ☐ Neuromuscular Re-education
- ☐ Proprioceptive Program

MODALITIES:

- ☐ Ultrasound
- ☐ Hot Pack
- ☐ Cryotherapy-Ice Packs
- ☐ Ice Massage
- ☐ Electrical Stimulation
 - ☐ a. Pain Control
 - ☐ b. Edema Control
 - ☐ c. Muscle Re-education & Strength Training
 - ☐ d. T.E.N.S
- ☐ Traction
 - ☐ a. Pelvic
 - ☐ b. Cervical
- ☐ Iontophoresis

I certify that outpatient physical therapy services are of a medical necessity to this patient. I will review this plan of care every 30 days while this patient is under my care.

MD/DDS/DPM/DO/DC