WELLS PHYSICAL THERAPY OF BOERNE

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Date: ________________________ Patient Ph. #: ________________

Name: ____

Diagnosis: ____

____

Date Return to Physician: ______________________________

Area(s) to be Treated: ________________________________

Precautions/Contraindications/WB Status: ________________________

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Frequency: ☐ Daily ☐ TIW ☐ BIW

Duration: ____

- ☐ Evaluate and Treat
- ☐ Manual Therapy/Mobilization
- ☐ Therapeutic Exercise
  - ☐ Range of Motion
  - ☐ Strengthening
  - ☐ Home Instruction
  - ☐ ____
- ☐ Gait Training
- ☐ Modalities
  - ☐ Moist Heat
  - ☐ Cryotherapy
  - ☐ Ice Massage
  - ☐ Biofeedback/Neuromuscular Re-education
  - ☐ Ultrasound
  - ☐ Phonophoresis
  - ☐ Iontophoresis
  - ☐ T.E.N.S.
- ☐ Treatment Goals
  - ☐ Relieve Pain
  - ☐ Reduce Spasm
  - ☐ Increase Function
  - ☐ Increase Strength

Physician Signature: ____