



# Total Rehab, P.C. Physical Therapy

Patient Name: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_ Physician Name \_\_\_\_\_

*PLEASE PRINT*

Diagnosis: \_\_\_\_\_

## Evaluation & Treatment

- |   |   |
|---|---|
| <input type="checkbox"/> TENS                     | <input type="checkbox"/> Iontophoresis          |
| <input type="checkbox"/> Paraffin                 | <input type="checkbox"/> Back Exercise          |
| <input type="checkbox"/> Passive Exercise         | <input type="checkbox"/> Home program           |
| <input type="checkbox"/> Traction                 | <input type="checkbox"/> Muscle re-education    |
| <input type="checkbox"/> Active Assisted Exercise | <input type="checkbox"/> Knee Brace             |
| <input type="checkbox"/> Manual Therapy           | <input type="checkbox"/> Gait Training          |
| <input type="checkbox"/> Strengthening Exercise   | <input type="checkbox"/> Lumbosacral Support    |
| <input type="checkbox"/> Relaxation Training      | <input type="checkbox"/> Home Traction Unit     |
| <input type="checkbox"/> Ultrasound               | <input type="checkbox"/> Electrical Stimulation |
| <input type="checkbox"/> CPM                      |   |

Frequency: \_\_\_ BID \_\_\_ QD \_\_\_ 1/wk \_\_\_ 2/wk \_\_\_ 3/wk \_\_\_  
once \_\_\_ other

Duration: \_\_\_ 1 wk \_\_\_ 2 wks \_\_\_ 3 wks \_\_\_ 4 wks  
\_\_\_ other \_\_\_

Remarks/Comments/Limitations/Weight Bearing:

Physician Signature \_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_