

SALMON CREEK PHYSICAL THERAPY

SPORTS CARE • WORK INJURY • REHABILITATION

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Patient's Name: _____ Diagnosis: _____

Telephone Number: _____ Insurance: _____

Radiograph Result/Precautions: _____

Recommended Frequency: ___ Daily ___ 3x ___ 2x ___ 1x Duration: _____ Weeks

___ EVALUATE AND TREAT

TREATMENT PLAN

- ___ Joint Mobilization
- ___ Gait Training
- ___ Range of Motion
- ___ Strength Training
- ___ Spinal Rehab Program
- ___ Ankle Rehab Program
- ___ Shoulder Rehab Program
- ___ Knee Rehab Program
- ___ Home Exercise Program

Recommended Modalities: _____

GOALS

- ___ Improve Strength/ROM
- ___ Decrease Pain
- ___ Maximize Joint Function
- ___ Decrease Inflammatory Reaction
- ___ Improve ADL Function
- ___ Independent Home exercise Program
- ___ Improve Posture/Body Mechanics
- ___ Return To Work

Signed: _____

Date _____ / _____ / _____