



PRESCRIPTION & TREATMENT PLAN

Patient's Name _____ Date of Birth _____

Home Phone _____ Work Phone _____

Date of Injury _____ Employer _____

Insurance Company _____ Phone _____

Adjuster _____ Claim # _____

DIAGNOSIS:

SPECIAL INSTRUCTIONS:

_____ Evaluate & Treat	_____ Stabilization Program
_____ Therapeutic Exercise	_____ Aerobic Conditioning
_____ Joint Mobilization	_____ Gait Training
_____ Soft Tissue Mobilization	_____ Traction
_____ Home Exercise Program	_____ Modalities

FREQUENCY: _____ times/week for _____ weeks

DURATION: Start date: _____ to: _____ Total Treatments: _____

SPECIFIC GOALS:

Pain:

Strength:

Active Range of Motion:

Functional Abilities:

Referred by Dr. (please print) _____ Phone _____ Fax _____

Physician's Signature: _____ Date ____/____/____