



The One on One Approach!

Patient Name: _____

Phone Number: _____ Insurance: _____

Diagnosis: _____

Precautions/Weight Bearing Status: _____

Goals: _____

Frequency/Duration: _____ x wk / _____ x weeks

Evaluation & Treatment

Therapeutic Exercise

- Range of Motion
- Muscle Strengthening
- Balance Retraining
- Neuromuscular Re-ed
- Gait Training
- Joint Mobilization
- Soft Tissue Mobilization
- Traction
- Back Stabilization
- Back Education
- Lifting Mechanics
- Work Tolerance/Endurance
- ADL Training
- Ergonomics Assessment
- Job/Work Site Analysis
- Wheel Chair Assessment
- Other: _____

Modalities

- Tens
- Interferential
- HVPC
- Russian Stim
- Bio Feedback
- Ultrasound
- Paraffin
- Heat/Cold Therapy
- Other: _____

M.D. Signature: _____ Date: / /

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