CENTRAL VALLEY PHYSICAL THERAPY

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PATIENT'S NAME: ______________________ PATIENT'S PHONE: ______________

DIAGNOSIS: ______________________ DOB: ______________

PRECAUTIONS: ______________________

PHYSICAL THERAPY

- ☐ **Evaluate and Treat**
- ☐ Therapeutic Exercise (Active, Passive, PRE)
- ☐ Functional Activities (Gait, Balance, ADL)
- ☐ Neuromuscular Re-education
- ☐ Manual Therapy (Joint & Soft Tissue Mobilization)
- ☐ Modalities (Elect Stim, Iontophoresis, Vasopneumatic Compression)
- ☐ Thermal Modalities (Ice, Moist Heat)
- ☐ Traction (Lumbar, Cervical)
- ☐ Comments: ______________________

SPECIALIZATION IN

- ☐ Orthopedic Physical Therapy
- ☐ Sports Physical Therapy

Comments / Parameters: ______________________

Frequency: ________ times per week for _____ weeks Signature: ______________ Date: ____________

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