RAINIER FAMILY

physical therapy, ps

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Name____________________________Date__________

Diagnosis____________________________________

Date of Injury/Surgery___________________________

Precautions/Comments___________________________

☐ Evaluate and treat per Therapist's discretion
☐ Evaluate and treat with recommendations as below

MODALITIES/PROCEDURES

☐ Heat/Ice
☐ Ultrasound
☐ Iontophoresis
☐ Electrical Stimulation
☐ TENS
☐ Manual Traction
  ☐ Cervical
  ☐ Lumbar
☐ Joint Mobilizations
☐ Soft tissue mobilization
☐ Myofascial Release
☐ Strain/Counterstrain
☐ Gait Training
☐ Functional Activity/Training
☐ Home Exercise Program
☐ ROM/Stretching
☐ Balance/Proprioception
☐ Core Stabilization

ADDITIONAL NOTES:

Physician's Signature___________________________

Physician's Name (printed)______________________

See reverse side for a map to this location!