

SPORTS + ORTHOPEDIC LEADERS PHYSICAL THERAPY, INC.



Patient: _____

Dx: _____

Rx: _____

PHYSICAL THERAPY EVALUATION + TREATMENT

Please focus treatment on:

Manual Therapies:

Active Release Techniques® soft tissue treatment (myofascial techniques)

Joint mobilization

Proprioceptive neuromuscular facilitation

Therapeutic Activities:

Functional mobility

Strengthening

Neuromuscular re-education

Balance

Proprioception

Gait assessment + training

EMG muscle trainer

Sport specific training program

Postural education + awareness

Peripheral or spinal stabilization progression

Pilates-evolved rehab + conditioning

Home exercise program

Modalities:

Ice

Heat

Photonic stimulation (infrared)

Vasopneumatic compression

Ultrasound

Cold Laser

Biofeedback

Electrotherapies:

Interferential current

Electrical muscle stimulation

Microcurrent

Iontophoresis

Traction

Supplies:

Taping programs: knee shoulder spine ankle/foot orthotics

Recommended Frequency and Duration: _____ times per week for _____ weeks

Comments (precautions/contraindications): _____

Physician's Signature: _____ **Date:** _____

P.T. Comments: _____

We are members of the Preferred Therapy Providers Network. Please call to see if your PPO is a part of our network.

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