

BATTLE GROUND / RIDGEFIELD
PHYSICAL THERAPY
WORK AND SPORTS INJURY CENTER

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PATIENT: _____ Phone: _____

Diagnosis: _____

Goals: _____

PLAN OF TREATMENT

- PT Evaluate and Treat

Modalities

- Ultrasound
- Heat
- Ice
- Massage
- Traction – Cervical
- Traction – Pelvic
- TENS/electrical stimulation
- Interferential Current
- Iontophoresis

Procedures:

- Exercises
 - ROM/Mobilization
 - Assistive
 - Active
 - Resistive
- Gait Training/Balance Training
- Relaxation Training for Headaches
- Back/Neck Education/Exercises
- Home Program

Precautions/Special Instructions: _____

Frequency: (Circle) 5x, 4x, 3x, 2x, 1x per week. Duration: _____ weeks.

I certify that this treatment plan is medically necessary.

Signed: _____ **Date:** _____

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