NORTH PLATTE PHYSICAL THERAPY

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CARE PLAN / CERTIFICATION / MONTHLY SUMMARY

Patient Name _____ Age _____ Sex _____
Address _____ Dr. _____
Diagnosis _____
Onset Date _____ Pt. aware of DX _____ yes _____ no

TREATMENT

_____ Evaluate and Treat
_____ Therapeutic Exercise
- _____ Home Program
- _____ Passive
- _____ Active Assistive
- _____ Active
- _____ PRE
- _____ Neuro Re-ed/Vestibular Rehab
- _____ Proprioceptive/Balance

_____ Gait Training
_____ Functional Performance Testing
_____ Brace Fitting

CERTIFICATION From _____ To _____

_____ Mobilization/Manual Therapy
_____ TDN
_____ Modalities
- _____ Ultrasound/Phonophoresis
- _____ Light Therapy
- _____ Iontophoresis

_____ Electrical Stimulation
- _____ IFC
- _____ Functional Estim
- _____ TENS

_____ CPM Machine
_____ Traction

Progress Summary: Improvements seen in ___ Pain Control ___ Swelling ___ ROM ___ Strength
___ Functional Mobility/Gait ___ Other (details)

_____

_____

_____

_____ Discharged _____ Continued Service

Other _____

Frequency _____ Duration _____

Goals _____

_____

Rehab Potential: _____ Comments _____

Therapist _____

Physician Signature _____ Date _____