

ACTIVE

Physical Therapy & Associates

Jim Miller PT, DC Kay Miller PT

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Website: ActivePT.org

Patient Name: _____ D.O.B.: _____ Claim #: _____

Diagnosis/Surgery: _____

Physician: _____

EVALUATE & TREAT

Modalities

- Hot pack
- Cold pack
- Ultrasound
- Electrical Stimulation
- Massage/MFR
- Taping
- Modalities PRN: at PT's discretion

Program

- Aquatic Program
- McKenzie Program
- Lumbar Stabilization Program
- Patella Femoral Program
- Mensical Repair Program
- ACL, Post-Op Rehab Program
- Foot and Ankle Program
- Shoulder RTC repair/decompression
- Shoulder Labral Repair
- Elbow Rehab
- Neck Rehab

Exercises

- Active ROM
- Passive ROM
- Mobilization
- Stretching
- Strengthening
- Isometrics
- PRE's
- Conditioning
- Balance/Proprioception
- Gait Training
- Home Program
- Other _____

GOALS OF TREATMENT

- Decrease pain
- Increase Strength
- Increase ROM/ Flexibility
- Increase Endurance
- Increase Proprioception
- Improve Functional Abilities
- Improve Gait, Weight Bearing Status _____
- Progress Weight Bearing to _____
- Other _____

FREQUENCY OF TREATMENT

- Standard Treatment Plan:
 - 2 days a week for: 4 6 8 weeks
- Other Frequency of Treatment: _____ days a week for _____ weeks

PHYSICIAN SIGNATURE _____

DATE _____

COMMENTS _____

My signature authorizes this treatment to be medically necessary.