Wellworks
Physical Therapy and Rehabilitation Inc.

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Patient Name____

Diagnosis____Onset_____________________

Precautions/Special Instructions____

Evaluation and Treatment

- ☐ ROM: PROM / AROM / AAROM
- ☐ Muscle Strengthening / Stretching
- ☐ Gait Training / Balance Training
- ☐ Sensory Reeducation / Desensitization
- ☐ Edema and Scar Control
- ☐ ADL / Adaptive Equipment
- ☐ Home Exercise

Special Programs

- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Hand Therapy
- ☐ Sports & Fitness Training
- ☐ Arthritis Rehabilitation
- ☐ Parkinson's Rehabilitation
- ☐ Other: ______________________

Modalities and Procedures

- ☐ Ultrasound
- ☐ Electrical Stimulation
- ☐ Biofeedback
- ☐ Paraffin
- ☐ Hot Pack/Cold Pack
- ☐ Whirlpool
- ☐ Other: ______________________

Traction

- ☐ Mechanical
- ☐ Manual

Splinting and Taping

- ☐ Static / Dynamic
- ☐ McConnell / Kinesiotaping

Frequency of Treatments: _______ times per week for _______ weeks

❍ Initial Certification ❍ Re-Certification

I certify that I have examined the patient, deemed that therapy is necessary, service will be furnished while the patient is under my care, and that the therapy plan is established and will be reviewed every 30 days, or more often as required by the patient's condition.

_________________________________ _________________________
(PHYSICIAN SIGNATURE) (DATE)

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(NAME PRINTED)