NORTH VALLEY PHYSICAL THERAPY

" One On One Care"

Patient Name: _____ **Date**_____

Diagnosis: _____

Frequency / Duration : [ ] 2x/wk. [ ] 3x/wk. [ ] 4x/wk. [ ] 5x/wk. For: _____wks

[ ] P.T. Evaluation and Treatment:

[ ] Theraputic Exercise
- [ ] Spine Program
- [ ] Strengthening
- [ ] Stretching Program
- [ ] Range Of Motion
- [ ] Home Exercise Program

[ ] Vertigo
- [ ] BPPV

[ ] Massage Therapy
- [ ] Myofacial Release

[ ] Joint Mobilization

[ ] P.T. Evaluation and Treatment:

[ ] Aquatic Therapy
- [ ] Pool
- [ ] Whirlpool

[ ] Modalities
- [ ] Electrical Stimulation
- [ ] Ultrasound
- [ ] Hot/Cold Pack
- [ ] Parafin Bath

[ ] Functional Training
- [ ] Gait
- [ ] Transfers
- [ ] Balance
- [ ] Stroke Rehabilitation

[ ] Traction
- [ ] Manual
- [ ] Mechanical

Special Instructions: _____

Physician Signature: _____

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