

DAY ONE

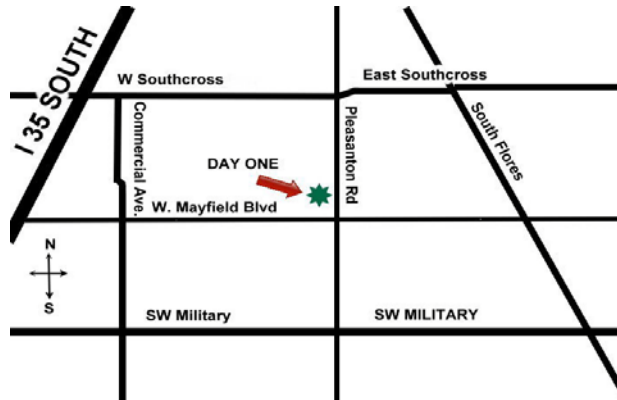
PHYSICAL THERAPY & WELLNESS

1939 Pleasanton

SAN ANTONIO, TX 78211

(Located at the intersection of Pleasanton and W. Mayfield Blvd.)

Tel. (210) 922-8300 Fax: (210) 922-8304



PATIENT NAME _____ DATE: _____

Diagnosis: _____ Diagnosis Code (s): _____

Surgery _____ Precautions: _____

FREQUENCY: 1 2 3 4 5 6 visits/week

DURATION: 1 2 3 4 5 6 7 8 weeks

Evaluate & treat as indicated: _____

**Therapeutic Exercise/
Activities**

Manual Therapy

Modalities

- As indicated per P.T.
- PROM/AAROM/AROM
- Strengthening
- Stretching
- Neuromuscular Re-ed
- Proprioceptive Training
- Gait Training
- Other: _____

- As indicated per P.T.
- Joint Mobilization
- Soft Tissue Mobilization
- Myofascial Release
- Other _____

- As indicated per P.T.
- Hot/Cold Pack
- Ultrasound
- E-Stim
- NMES
- Traction
- Other

Physician Signature

Date

I certify that the prescribed treatment is an appropriate course of and the services prescribed are medically necessary.