



**PHYSICAL
THERAPY
ASSOCIATES INC.
OF NEPA**

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Name: _____ Diagnosis: _____ Date: _____

PHYSICAL THERAPY

Times/Week: 1 2 3 4 5

Weeks: 1 2 3 4

- _____ Evaluation
- _____ Cryotherapy
- _____ Moist Heat
- _____ Paraffin
- _____ Whirlpool
- _____ Ultrasound
- _____ Electrical Stimulation
- _____ TENS
- _____ Iontophoresis
- Medication _____
- _____ Phonophoresis
- Medication _____
- _____ Neuroprobe
- _____ Traction (circle)
- Cervical Pelvic

- _____ Passive Stretching
- _____ Manual Therapy
 - Massage
 - Mobilization
 - Myofascial release
 - Strain/counterstrain
 - MET
- _____ Therapeutic Exercise
 - Joint ROM
 - AAROM
 - Isometric
 - Isokinetic
 - Gait Training
 - PROM
 - AROM
 - PRE's
- _____ Home Exercise Program
- _____ McKenzie Method - Spine

- _____ Specialized Taping
(i.e. McConnell, Kinesio)
- _____ Progressive Ambulation
 - NWB
 - PWB
 - FWB
- _____ Lido Isokinetic Testing
 - Back
 - Extremities

Comments:

Signature: _____