PHYSICAL, OCCUPATIONAL & SPEECH THERAPY SPECIALISTS

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❒ **PRYOR CLINIC** — 165 Steve Barry Blvd. • Pryor, OK 74361
(918) 824-4500 • Fax (918) 824-1977
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Patient Name: ______________________________ Phone ______________

Date of Onset: ______________ Next Dr. Appt: ______________ ICD-9 Code: ______________

Diagnosis: ______________________________ Weight Bearing Status: ________

Evaluate and Treat as Indicated: _______PT ______OT ______ST

Special Instructions/Precautions: ______________________________

____

Rehabilitation Programs:

❒ Neck ❒ Back ❒ Shoulder ❒ Hand ❒ Elbow ❒ Hip
❒ Knee ❒ Foot/Ankle ❒ Stroke ❒ Spine ❒ Balance ❒ Gait Training ❒ Aquatic Therapy

MODALITIES

❒ Modalities as Indicated
❒ Moist Heat
❒ Cold Pack
❒ Diathermy
❒ Electrical Stimulation
❒ Ultrasound
❒ Phonophoresis
❒ Iontophoresis
❒ Tens Application
❒ Traction Neck/Back
❒ Massage
❒ Soft Tissue Mobilization
❒ Whirlpool
❒ Wound Care ________

EXERCISES

❒ Passive
❒ Active Assistive
❒ Active
❒ Resistive
❒ Mobilization
❒ Stretching
❒ Isometrics
❒ Muscle Strengthening (PRE)
❒ Gait Training
❒ Home Exercise Instruction

❒ **ISOKINETIC EVALUATION**

❒ **FUNCTIONAL CAPACITY EVALUATION**

❒ **PRE-OPERATIVE PROTOCOL**

❒ **HAND THERAPY**

❒ **HAND SPLINTING**
  ❒ **STATIC**
  ❒ **DYNAMIC**

WORK CONDITIONING

❒ Daily
❒ Three times a week
❒ Treatment Goals as per therapist's discretion unless otherwise noted below
Other ______________________________

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Frequency (times per week): ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5

Duration (in weeks): ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6

Signature certifies the established plan of care.

Physician Signature: ______________________________ Date: ______________

Physician's Name (printed): ______________________________