



physical therapy • fitness training

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Patient Name _____ Date _____

Diagnosis _____

ICD-9 code _____ Injury date _____

Surgery _____ Surgery date _____

___ Physical therapy evaluation and treatment

___ Therapeutic Exercise

___ Cold/Heat

___ Soft tissue mobilization

___ Electrotherapy

___ Joint Mobilization

___ Ultrasound

___ Home Exercise program

___ Traction

Special instructions: _____

___ x/week for ___ weeks

Physician name _____

Physician phone # _____

Physician Signature _____