Company Name

PHYSICAL THERAPY PLAN OF CARE

Date: _____ Time: _____

Patient: _____ ID#: _____

Diagnosis: _____

VISIT:

- ☐ 1. Therapeutic Exercise
  - ☐ Passive
  - ☐ Active Assistance
  - ☐ Active
  - ☐ Resistive
- ☐ 2. Progressive Resistive Ex
- ☐ 3. Muscle Re-Education
- ☐ 4. Balance Training
  - ☐ Frankel Exercise
  - ☐ Other
- ☐ 5. Transfer Training
  - ☐ Supine to sitting on or side of bed ☐ Reverse
  - ☐ Sitting to standing ☐ Reverse
  - ☐ Bed to chair ☐ R[illegible]rse
  - ☐ Chair to commode ☐ Re[illegible]
  - ☐ Chair to car ☐ Rev[illegible]se
  - ☐ Chair to bathtub ☐ [illegible]
- ☐ 6. Heat Type:_____
- ☐ 7. Therapeutic Massage
- ☐ 8. Prosthetic Training
- ☐ 9. Elect Stimulation
- ☐ 10. Wheelchair Mc

ASSESSMENT

- ☐ 11. Gait Training
  - ☐ Walker
  - ☐ Crutches
  - ☐ Cane
  - ☐ Braces
  - ☐ Stairs, Step[illegible] Curb
- ☐ 12. Stretching
- ☐ 13. Relaxation Tec[illegible]que
- ☐ 14. Codmans
- ☐ 15. Williams[illegible]ion
- ☐ 16. Buerg[illegible]er Al[illegible]n
- ☐ 17. H[illegible]ory
  - ☐ P[illegible]tural Drainage
  - ☐ Per[illegible]ssion, Vibration
  - ☐ Br[illegible]athing exercises
- ☐ [illegible]3. Ultrasound Rx:_____
- ☐ 19. Other Treatment:_____
- ☐ 20. Contraindication:_____
- ☐ 21. Precautions:_____
- ☐ 22. Observations:_____

Frequency and Duration:_____

Problems: _____

Goals: _____

Comments: _____

Print Therapist Name	Therapist Signature	PTA Signature	Date

Print Physician Name	Physician Signature	Date