Camas PHYSICAL THERAPY

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Patient Name: _____ **Phone:** _____ **D.O.B.** _____

ICDIO CODES: _____

DIAGNOSIS: _____

_____

_____

SPECIAL INSTRUCTIONS: _____

_____

_____

PRECAUTIONS: _____

_____

_____

IMAGING RESULTS: _____

_____

_____

FREQUENCY:
- ☐ as required
- ☐ daily
- ☐ T I W
- ☐ _____ Rx only

DURATION: _____ week(s)

- ☐ Evaluate and RX as needed with report to Doctor
- ☐ Work Conditioning
- ☐ PCE/FCE

☐ **MODALITIES:**
- ___ cryotherapy
- ___ iontophoresis
- ___ cervical traction
- ___ lumbar traction
- ___ biofeedback
- ___ moist heat
- ___ ultrasound
- ___ E-stim/TENS
- ___ NMES
- ___ laser

☐ **PROCEDURES:**
- ___ massage
- ___ joint mobilization
- ___ vestibular rehab
- ___ therapeutic exercise
- ___ trigger point therapy
- ___ radial shock wave
- ___ strain counterstrain
- ___ ASTIM

- ☐ Home Exercise Program
- ☐ Back School Education
- ☐ Headache Program
- ☐ Gait Training
- ☐ TMJ Evaluation/Treatment
- ☐ Physical Capacities Evaluation
- ☐ Orthotics

Signed: _____

Print Doctor Name: _____

Date: _____ **Phone:** _____