PROGRESSIVE THERAPY

RX

Name:_____ Date:_____

Diagnosis:_____

Date of Onset:_____

Precautions:_____

Medical History:_____

_____

_____

Treatment Program: _____PT _____OT _____ST

_____Evaluate and Treat as Needed

Signature:_____

Return to M.D. Date:_____

Rehabilitation Services:

_____Evaluation & Treatment
_____Hand Rehabilitation
_____ADL Eval/Training
_____Work Hardening
_____Moist Heat
_____Therapeutic Exercise
_____Impairment Rating
_____Gait Training
_____Work Conditioning
_____Ultrasound
_____Splinting
_____Back Care Workshop
_____FCE
_____Therapeutic Activity

Other:_____

_____