OPTIMUM CARE THERAPY

Physical Therapy, Chiropractic Services and Sports Medicine

NAME:_____DOB:_____DATE:_____

DIAGNOSIS:_____DOI:_____

FREQUENCY:_____TIMES PER WEEK_____WEEKS. NEXT MD APPT._____

EVALUATION EVALUATION & TREATMENT

AREA/S TO BE TREATED: C-SPINE T-SPINE LS-SPINE SHOULDER ELBOW WRIST

HIP KNEE ANKLE OTHER:_____

TREATMENT PLAN:

PHYSICAL AGENT (HOT/COLD PACKS)	MANUAL THERAPY
THERAPEUTIC EXERCISE	SOFT TISSUE MOBILIZATION/MYOSFASCIAL RELEASE
GAIT TRAINING	JOINT MOBILIZATION
ADL TRAINING	NEUROMUSCULAR REEDUCATION
AQUATIC THERAPY	MODALITIES: (E-STIM, ULTRASOUND, LIGHT THERAPY)
FUNCTIONAL ACTIVITIES	IONTOPHORESIS
MECHANICAL TRACTION	CORRECTIVE TAPING

OTHER:_____

PRECAUTIONS/ SPECIAL INSTRUCTIONS:_____

PHYSICIAN'S SIGNATURE :_____DATE:_____

OPTIMUM CARE THERAPY

17906 Pioneer Blvd. Suite 101 & 102 Artesia, CA 90701

Phone: (562) 865-2222 Fax: (562) 865-6999

www.octrehab.com