



CTY. RD. 96 & LEXINGTON AVE.
 PHONE (651) 484-6735
 FAX (651) 484-5663
 E-mail: clinics@motioncare.com
 www.motioncare.com

PATIENT: _____ DOB: _____ NEXT MD APPT: _____

DIAGNOSIS: _____

PERTINENT HISTORY: _____

PRECAUTIONS/CONTRAINDICATIONS: _____

FINDINGS: X-RAY,CT, MRI, EMG, OTHER: _____

PROGNOSIS: _____

ORDERS: Evaluate/Treat Evaluate/Consult Evaluate/Specific Order VO

PLANS: Hot/Cold Pack Ultrasound Massage Electronic Stimulations/TNS Iontol Phonophoresis Diathermy Contrast Bath Infrared	Mechanical Traction PROMIAROM Manual Therapy Back Exercise Neck Exercise Flexability Exercise Strength Exercise Vasopneumatic Other _____	GOALS: Increase ROM _____ Decrease Pain _____ Decrease Edema _____ Increase Strength _____ Decrease Spasm _____ Increase Flexability _____
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Frequency: 1X/wk 2X/wk 3X/wk 4X/wk 5X/wk Other _____

Duration: 1wk 2wk 3wk 4wk Other _____

Physician's Name _____

Therapist's Name _____

Physician's Signature _____

Date _____

Therapist's Signature _____

Date _____