



ATTA REHAB

99-1 15 AIEA HEIGHTS DR · SUITE 253 · AIEA, HI 96701

PHONE: 808.773.8811

FAX: 808.495.4418 / 808.773.7111

Patient Name: _____

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Workers Comp | <input type="checkbox"/> No Fault/MVA |
| <input type="checkbox"/> Medicare _____ | <input type="checkbox"/> Other _____ |

Phone: _____ Date of Injury: _____ DOB: _____

Diagnosis 1: _____ ICD-10: _____

Diagnosis 2: _____ ICD-10: _____

Frequency/Duration: _____ Times per week for _____ Weeks OR _____ Total visits

Precautions/Special Instructions: _____

Goals/Measurable objectives: _____

PHYSICAL THERAPY EVALUATE & TREAT

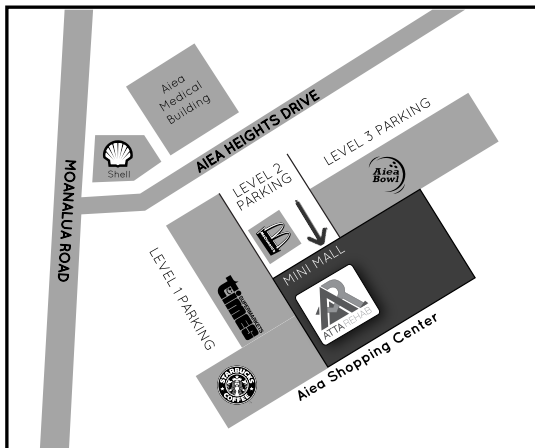
Procedures		
<input type="checkbox"/> Joint mobilization/ROM	<input type="checkbox"/> Myofascial Release	<input type="checkbox"/> Soft Tissue Mobilization
<input type="checkbox"/> Strain-Counterstrain	<input type="checkbox"/> McConnell/Kinesio Taping	<input type="checkbox"/> Bracing

Therapeutic Exercises		
<input type="checkbox"/> Progressive Resistance Training	<input type="checkbox"/> Neck/Back program	<input type="checkbox"/> Elbow/wrist/hand program
<input type="checkbox"/> Gait training	<input type="checkbox"/> Shoulder program	<input type="checkbox"/> Vestibular Rehab
<input type="checkbox"/> Reactive Neuromuscular training	<input type="checkbox"/> Foot/Ankle program	<input type="checkbox"/> ACL Protocol
<input type="checkbox"/> Core/Stabilization Training	<input type="checkbox"/> Hip/knee program	<input type="checkbox"/> Rotator Cuff Protocol

Modalities			
<input type="checkbox"/> Traction Cervical/Lumbar	<input type="checkbox"/> Electrical Stimulation	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Iontophoresis

Physician Signature: _____ Date: _____

Physician Name: _____



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