Sports, Back & Pain Management Clinic

BODIES IN MOTION LIFELONG HEALTH

2714 Osler Blvd * Bryan, TX * (979) 776-2225 * FAX (979) 776-7945 * BVphysicaltherapy.com

PHYSICAL THERAPY PATIENT PLAN OF CARE

Patient Name_____ **DOB:** _____ **Date:** _____

Diagnosis_____

Precautions_____

Duration of Treatment_____

Frequency ☐ weekly ☐ biweekly ☐ T/W ☐ daily for _____weeks

Comments_____

[ ] Evaluate & Treat

Specialty Programs

- [ ] Pain Management
- [ ] TMJ/Headache Program
- [ ] Pelvic Pain
- [ ] Incontinence
- [ ] Balance/Fall Prevention
- [ ] Weakness
- [ ] Post Surgical Program
- [ ] Stroke Rehabilitation
- [ ] Cardiopulmonary Rehab
- [ ] Biofeedback
- [ ] Diabetic Peripheral Neuropathy
- [ ] Dry Needling
- [ ] Fibromyalgia
- [ ] Osteoporosis Program
- [ ] Arthritis
- [ ] NCS/EMG testing
- [ ] FCE
- [ ] Work injury/Return to Work
- [ ] Orthotics Fabrication/Fitting
- [ ] Prosthetic Fit/Instruction
- [ ] Wheelchair Assessments
- [ ] Weight Management Program
- [ ] Activity Prescription Program
  - *General Exercise/Disease Prevention
  - *Diabetes Management through Activity

Notice: This list is intended at a guideline; it is not an all-inclusive list.

TREATMENT GOALS: ↓ Pain, ↓ Spasm, ↓ Swelling, ↑ Strength, ↑ ROM, ↑ ADL, ↑ Healing

---

I certify that physical therapy services for the above-named patient are or were medically necessary

A. On an outpatient basis.
B. Under a plan established and reviewed within 30 days by me as attending physician.
C. While the patient is or was under my care.
D. The patient is aware of their diagnosis and prognosis.

Further, the written plan established is contained in the patient's record and prescribes the type, amount, and duration of the physical therapy.

Physician Signature _____