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PATIENT NAME _____ PHONE _____

DATE _____

(see map on reverse side)

DIAGNOSIS _____

SPECIAL INSTRUCTIONS _____

SPLINTING _____

PRECAUTIONS _____

X-RAYFINDINGS _____

- FREQUENCY as required
 daily
 TIW
 _____ visits

DURATION _____ weeks

- Evaluate and R_x as needed wih report to Doctor
- Kinetics - Therapeutic Exercise
- Pool Therapy with Exercise
- Work Conditioning
- Physical Capacities Evaluation
- ROM ___ Passive ___ Active
- MODALITIES
 - ___ Cold pack ___ Moist heat
 - ___ Traction ___ Ultrasound
 - ___ Paraffin ___ Galvanic
 - ___ TENS
- PROCEDURES
 - ___ Massage ___ Joint mobilization
 - ___ Neurological ___ Trigger point
 - ___ re-education ___ therapy
- Back School Education
- Iontophoresis/Phonophoresis
- Scar Management/Desensitization
- Home Exercise Program
- TMJ Evaluation and Treatment

signed _____ M.D.