**Physical Therapy Treatment Plan**

**Landmark Healthcare, Inc.**

**FAX (888) 565-4225**

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### PATIENT'S CURRENT MEDICAL HISTORY

**Anticipated No. of Visits**

**Patient Phone (area code first)**

**Date of first tx at this office for this condition**

**ICD-9 Code:**

1. **Primary**
2. **Secondary**
3. **Additional**
4. **Additional**

**Description:**

**Pain Scale (0-10):**

- **10**
- **9**
- **8**
- **7**
- **6**
- **5**
- **4**
- **3**
- **2**
- **1**

**Anticipated Release Date**

**Date of Submission**

**Date of Initial Evaluation**

**Mechanism of Onset for Primary Diagnosis**

- **Acute Trauma**
- **Worsening of prior illness/injury**
- **Repetitive Motion**
- **Gradual Onset**
- **Chronic**
- **Other**

**Description:**

**Objective Findings**

**Date Obtained**

**Inspection/Palpation:**

**Spinal Range of Motion**

- **Cervical ROM**
  - **Flexion**
  - **Extension**
  - **R.Lat.Flex**
  - **L. Lat. Flex**
  - **R. Rotation**
  - **L. Rotation**

**Extremity Range of Motion**

- **Lumbar ROM**
  - **Flex.**
  - **Ext.**
  - **Abduction**
  - **Adduction**
  - **Int. rotat.**
  - **Supination**
  - **Pronation**
  - **L Deviation**
  - **R Deviation**
  - **Opposition**
  - **Plantar flex**
  - **Dorsi flex**
  - **Eversion**
  - **Inversion**

**Activities of Daily Living**

- **Locomotion/movement**
  - **Bed mobility**
  - **Transfers**
  - **Walking**
  - **Stair climbing**

- **Self-care**
  - **Bathing**
  - **Dressing**
  - **Eating**
  - **Toileting**

- **Home management**
  - **Household chores**
  - **Shopping**
  - **Driving/transportation**
  - **Care of dependents**

- **Community and work activities**
  - **Work/School**
  - **Recreation or play activity**

- **Lifting/Carrying**
  - **Overhead**
  - **From waist**
  - **From floor**

**Complicating Factors**

- **Surgery**
  - **Date**
  - **Type**
  - **Precautions**

**Diagnoses**

**TREATMENT PLAN**

**Treatment Plan (MM/DD/YYYY)**

**From**

**To**

**Anticipated No. of Visits**

**Patient Home Care**

- **Stretching**
- **Exercise**
- **Hot/cold**

**I declare that the above information is true and correct to the best of my knowledge. Further, it is my professional judgment that physical therapy is not contraindicated for this patient. If I am required under state law to obtain a prescription prior to rendering this treatment, I have obtained such a prescription in compliance with state law.**

**Signature**

**Date**