Physical Therapy Treatment Plan

Landmark Healthcare, Inc.

FAX (888) 565-4225

Date of Submission ___/___/___

Please check type of care:
☐ Initial care ☐ Continuing care

INSURED

Patient Last Name	Patient First Name	M.I.	Gender ☐ M ☐ F	Age	Date of Birth (MM/DD/YYYY) ____/____/_____
Insured I.D. or SSN	Insured Last Name	M.I.	First Name		Patient Phone (area code first)
Patient Address	City			State	Zip Code

PAYOR

Employer Name	Insurance Company	Group Plan # or Union Local (Submit Copy of Patient's Insurance I.D. Card)	
Injury or illness is related to: ☐ Work ☐ Auto ☐ Other	Referring Physician/Practitioner	Doctor License #	Date of Referral ____/____/_____

PT/OT

Therapist Last Name	Therapist First Name	M.I.	Group Name		Provider/Group ID#
Provider/Group Address	City		State	Zip Code	Phone # ( ) Fax # ( )

PATIENT'S CURRENT MEDICAL HISTORY

Subjective Complaints:

Lost days from work to date __________ Days of work restriction to date __________

Mechanism of Onset for Primary Diagnosis

Date of Onset ___/___/_____ *Date of Initial Evaluation* ___/___/_____

☐ 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		Lumbar ROM
______°	Flexion	______°
______°	Extension	______°
______°	R.Lat.Flex	______°
______°	L. Lat. Flex	______°
______°	R. Rotation	______°
______°	L. Rotation	______°

Extremity Range of Motion *(Circle Painful Tests)*
Extremity: (specify)____________________

	Active (Degrees)	Passive (Degrees)	Manual Muscle Test Strength (0-5)
Flex.	R____/____L	R____/____L	R____/____L
Ext.	R____/____L	R____/____L	R____/____L
Abduction	R____/____L	R____/____L	R____/____L
Adduction	R____/____L	R____/____L	R____/____L
Int rotat.	R____/____L	R____/____L	R____/____L
Ext rotat.	R____/____L	R____/____L	R____/____L
Supination	R____/____L	R____/____L	R____/____L
Pronation	R____/____L	R____/____L	R____/____L
L Deviation	R____/____L	R____/____L	R____/____L
R Deviation	R____/____L	R____/____L	R____/____L
Opposition	R____/____L	R____/____L	R____/____L
Plantar flex	R____/____L	R____/____L	R____/____L
Dorsi flex	R____/____L	R____/____L	R____/____L
Eversion	R____/____L	R____/____L	R____/____L
Inversion	R____/____L	R____/____L	R____/____L

Summary of Clinical Findings (Orthopedic, Neurologic, Additional Info.)

Date of first tx at this office for this condition ____/____/_____ Anticipated Release Date ____/____/_____

DIAGNOSES

ICD Code:	Description:	Pain Scale (0-10)
1. Primary ____________	______________________	_____/10
2. Secondary ____________	______________________	_____/10
3. Additional ____________	______________________	_____/10
4. Additional ____________	______________________	_____/10

TREATMENT PLAN

Treatment Goals (Functional Improvement and Outcomes Expected)

Treatment Plan (MM/DD/YYYY)
From ____/____/______
To ____/____/______

Anticipated No. of Visits ________

Patient Home Care
☐ Stretching ☐ Exercise ☐ Hot/cold

Complicating Factors *(Check any that apply and /or list)*
☐ Surgery: Date_____/______/_______
Type ________________________________
Precautions___________________________
____
☐ Poor tissue healing such as: pernicious anemia, diabetes, thyroid disease, pregnancy
Other: _______________________________

Activities of Daily Living

Functional Limitations (check all that apply)

- ☐ Locomotion/movement
  - ☐ Bed mobility
  - ☐ Transfers (such as moving from bed to chair, from bed to commode)
  - ☐ Walking __________________(Duration/Distance)
  - ☐ Stair climbing
- ☐ Self-care (such as bathing, dressing, eating, toileting)
- ☐ Home management (such as household chores, shopping, driving/transportation, care of dependents)
- ☐ Community and work activities
  - ☐ Work/School
  - ☐ Recreation or play activity
- ☐ Lifting/Carrying
  - ☐ Overhead ________________ lbs.
  - ☐ From waist ________________ lbs.
  - ☐ From floor ________________ lbs.
- ☐ Other ______________________________

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____________________