PHYSICAL THERAPY TREATMENT PLAN

Patient Name: _____ Date: _____

Subjective Symptoms: _____

Objective Symptoms: _____

Modality/Modalities To Be Used And Frequency: _____

Rational For Use Of Therapy

- ☐ Decrease Pain
- ☐ Decrease Inflammation
- ☐ Decrease Edema
- ☐ Decrease Stiffness
- ☐ Increase Range of Motion
- ☐ Increase Circulatory Status
- ☐ Increase Mobility
- ☐ Improve Mobility
- ☐ Other: _____

Short Term Goals

- ☐ Walk Without Pain
- ☐ Return To Work
- ☐ Wear Shoes With Comfort
- ☐ Regular Duty ☐ Light Duty
- ☐ Other: _____

Long Term Goals

- ☐ Pain Free
- ☐ Resume Pre-Injury Activity Level
- ☐ Resume Normal Foot Function
- ☐ Resume Normal Heel To Toe Gait
- ☐ Regular Work Duty
- ☐ Prevent Need For Surgery
- ☐ Other: _____

Date treatment started: _____ Re-evaluate in _____ days/weeks/months.

_____
Doctors Signature

The American College of
FOOT & ANKLE ORTHOPEDICS
& MEDICINE

Name: _____ Date: _____
First Middle Initial Last

Address: _____
Street City State

Telephone: Home: _____ Work: _____

Sex: ☐Male ☐Female Birth Date: ____/____/____ Age: _____

Please tell us whom to thank for referring you: _____

CHIEF COMPLAINT

Describe your primary foot problem:

_____

_____.

How long has it been bothering you? _____

Any past foot problems? _____

Shoe Size: _____ Height: _____ Current Weight: _____

What is your occupation? _____

Do you ☐ sit at your job ☐ stand at your job ☐ sit and stand at your job?

Are you required to wear any particular type of work shoe? If yes, what type? _____

COMPREHENSIVE MEDICAL HISTORY

Do you have or have you ever been treated for any of the following? (Check all that apply)

- ☐ Diabetes
- ☐ Heart Attack
- ☐ Other Heart Conditions
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Poor Circulation
- ☐ Phlebitis
- ☐ Anemia
- ☐ Rheumatic Fever
- ☐ Hepatitis, Liver Disease
- ☐ Blood Clots
- ☐ Stomach Ulcer
- ☐ Asthma
- ☐ Lung Disease
- ☐ Tuberculosis
- ☐ Gout
- ☐ Neurological Problems
- ☐ Spinal/Disc Disease
- ☐ Sciatica
- ☐ Epilepsy
- ☐ Headaches
- ☐ Arthritis
- ☐ Kidney Disease
- ☐ Intestinal Problems
- ☐ Bladder Problems
- ☐ Unexplained Weight Loss
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Hearing/Ear Disorder
- ☐ Lyme Disease
- ☐ Frequent Infections
- ☐ Cancer
- ☐ Psychiatric Problems
- ☐ HIV
- ☐ Abnormal Bleeding, Healing
- ☐ Pacemaker
- ☐ None Of These

Family/Primary Physician: _____
Name Location Telephone