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          ☐ Increase Range of Motion
☐ Decrease Inflammation  ☐ Increase Circulatory Status
☐ Decrease Edema         ☐ Increase Mobility
☐ Decrease Stiffness     ☐ Improve Mobility
☐ Other: _____________________________

Short Term Goals

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

Long Term Goals

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

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

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

Family/Primary Physician:  __________________________________________

Name                   Location                   Telephone