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(217) 222-6800 • FAX (217) 222-0037
- 927 BROADWAY, SUITE 100 • QUINCY, IL 62301
(217) 222-9300 • FAX (217) 222-9400
- 3652 STARDUST DR. • HANNIBAL, MO 63401
(573) 221-8800 • FAX (573) 221-1808
- 225 MAIN STREET • KEOKUK, IA 52632
(319) 524-4900 • FAX (319) 524-4895
- 55 TROY SQUARE • TROY, MO 63379
(636) 528-7333 • FAX (636) 528-7335
- 620 WABASH • CARTHAGE, IL 62321
(217) 357-9000 • FAX (217) 357-9013
- 1100 E. OUTER ROAD SOUTH 61, SUITE 1 • CANTON, MO 63435
(573) 288-3311 • FAX (573) 288-1223
- 1089 JASON PL. • CHATHAM, IL 62629
(217) 483-5858 • FAX (217) 483-5855
- 144 EVERGREEN PARKWAY • LEBANON, MO 65536
(417) 991-3440 • FAX (417) 991-3445

Patient's Name _____ Date of Birth _____ Date _____

Diagnosis _____ Phone # _____

- EVALUATE/TREAT** **PHYSICAL THERAPY** **OCCUPATIONAL THERAPY**

BACK CARE

- Back Education
- Williams Flexion
- McKenzie Extension
- Functional Lumbar Stabilization

MANUAL THERAPY

- TRACTION**
- Cervical
 - Lumbar

EXERCISE

- Active ROM
- Passive ROM
- AAROM
- HEP
- Postural Exercise

MODALITIES

- Phonophoresis
- Hydrotherapy
- Cryotherapies
- Electrical Simulation
- TENS
- Hot Packs
- Ultrasound
- Paraffin Bath

INDUSTRIAL SERVICES

- FCE
- Ergonomics Assessment
- Job Site Analysis/Modification

ADL/IADL RETRAINING

- Home Assessment
- Driving Assessment
- Wheelchair Assessment

TREATMENT GOALS:

- | | |
|-----------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Increase ROM | <input type="checkbox"/> Decrease Edema |
| <input type="checkbox"/> Increase Strength | <input type="checkbox"/> Decrease Pain |
| <input type="checkbox"/> Increase Mobility | <input type="checkbox"/> Home Program |
| <input type="checkbox"/> Sensory Re-Education | <input type="checkbox"/> Patient Education |
| <input type="checkbox"/> Other: _____ | |

Comments/Precautions _____

Frequency & Duration:

- Therapist Discretion
- 1 2 3 4 5 days/week (circle one)
- _____ weeks (number)
- Treatment Goals As Per Therapist Discretion Unless Otherwise Noted Above

Physician Signature _____
(I CERTIFY/RECERTIFY THAT SKILLED REHABILITATION SERVICES ARE NECESSARY)