

Physical Therapy Treatment Plan

Landmark Healthcare, Inc., 1750 Howe Ave., Suite 300, Sacramento, CA 95825

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 # ()

Subjective Complaints:

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:

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

PATIENT'S CURRENT MEDICAL HISTORY

Objective Findings Date Obtained ____/____/____

Inspection/Palpation:

Spinal Range of Motion

Cervical ROM

_____°	Flexion	_____°
_____°	Extension	_____°
_____°	R.Lat.Flex	_____°
_____°	L. Lat. Flex	_____°
_____°	R. Rotation	_____°
_____°	L. Rotation	_____°

Lumbar ROM

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-9 Code:	Description:	Pain Scale (0-10)
1. Primary _____	_____	____/10
2. Secondary _____	_____	____/10
3. Additional _____	_____	____/10
4. Additional _____	_____	____/10

Treatment Goals (Functional Improvement and Outcomes Expected)

TREATMENT PLAN

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 _____

KAM012108