UNITED REHAB PROVIDERS

Evaluation

Evaluation at home

Patient ____________________ Date ____________

Diagnosis ______________________________

Frequency & Duration ____________

MODALITIES	EXERCISE	MANUAL TREATMENT	SPECIALIZED PROGRAMS
❑ ULTRASOUND	❑ STRENGTHENING	❑ JOINT MOBILIZATION	❑ GAIT ASSESSMENT/TREATMENT
❑ COLD PACKS	❑ ROM	❑ MYOFASCIAL RELEASE	❑ BACK SCHOOL
❑ HOT PACKS	❑ ISOMETRIC	❑ SOFT TISSUE MASSAGE	❑ WORK HARDENING
❑ ELECTRICAL MUSCLE STIMULATION	❑ ISOKINETIC	❑ HAND REHAB	❑ HOME EXERCISE PROGRAM
❑ TENS	❑ LUMBAR STABILZATION EXERCISES	AROM ____________	❑ GENERAL CONDITIONING
❑ INTERFERENTIAL	❑ PROPRIOCEPTIVE AND BALANCE TRAINING	PROM ____________	❑ VESTIBULAR REHABILITATION
❑ ULTRASOUND WITH E-STIM	❑ WILLIAM'S EXERCISE/MCKENZIE EXERCISE	PRECAUTIONS (IF ANY)	BALANCE TRAINING
❑ INFRARED THERAPY FOR DIABETIC NEUROPATHY	❑ OTHER ____________	____________	
❑ CERVICAL TRACTION	❑ PRECAUTIONS ____________	____________	
❑ BIOFEEDBACK			
❑ JOBST MEASUREMENT/COMPRESSION			
❑ ANODYNE			

Physician Signature ______________________ Phone # ____________