KAREN MORGAN PHYSICAL THERAPY

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Patient Name:			
DOB:		Phone:	
Email:			
Start Date:		End Date:	
Visits:		Frequency:	
ICD-10 Codes:			
Insurance:		ID/Case #:	
Notes/Precautions:			

Treatment Plan: please check all that apply			
☐	Evaluate and Treat at Therapist's Discretion		
☐	Aerobic Capacity/Endurance Training		
☐	Balance/Coordination/Agility Training		
☐	Body Mechanics	☐	Neuromuscular Reeducation
☐	General Balance	☐	Perceptual/Vestibular
☐	Falls Prevention	☐	Postural Control
☐	Motor Control and Learning	☐	Task Specific Performance Training
☐	Flexibility Program	☐	Gait Analysis/Re-Training
☐	Soft Tissue Mobilization	☐	Relaxation Training
☐	Strength Training		
☐	Head and Neck	☐	Trunk
☐	Upper Limb	☐	Lower Limb
☐	Ventilatory	☐	Pelvic-Floor

Signature:		Date:	