

NJ KNEE AND SHOULDER CARE P.C.

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PHYSICAL THERAPY PRESCRIPTION

NAME : _____ DATE OF REFERRAL: _____

DATE OF BIRTH : _____

DIAGNOSIS: _____

SPECIFIC INSTRUCTIONS (AS NEEDED): _____

☒ Evaluate & Treat

☐ Home Safety Evaluation

☐ Home Equipment/ Modification Assessment and Training

☐ Modalities

☐ Hot / Cold Packs

☐ Ultrasound

☐ Electrical Stimulation

☐ Paraffin

☐ Vasopneumatic Device

☐ Traction

☐ Therapeutic Exercise

☐ Range of Motion

☐ Strengthening

☐ Stretching

☐ Neuromuscular Re-Education

☐ Gait Training

☐ Massage/ Soft Tissue Work

☐ Manual Therapy / Joint Mobilization

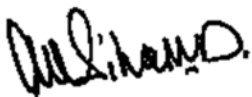
☐ Kinetic/ Therapeutic Activities

☐ Home Exercises

☐ Acupuncture Treatment

2-3 Number of Visits Per Week

4-6 Weeks (Treatment Duration)



ANJANI SINHA, M.D.

GOALS:

Improve ROM

Improve Strength

Improve Mobility

Improve Function