|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Physical Therapy Treatment Plan** | | | | |  |  |  | Date \_\_\_ / \_\_\_ / \_\_\_\_\_\_\_\_ | | | |  |  |
|  |  |  |  |  |  |  |  |  |
| **Any School Care,** 1111 Street Way, Any Town, TX 77777 | | | | | | |  | Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| FAX (888) 123-4567 | |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Patient Name** |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Age** |  |  |  |  |  |  |  | **Gender** | | | **\_\_\_ M or \_\_\_ F** |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Therapist Name** |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  | |  |  |
| **Goniometer** |  | **Make** |  |  |  |  | **Type** | |  |  | |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | |  | |  |  |  |  |  |  |  |  |  |  |
| **Complaint (any discomfort or pain):** | | | | |  |  |  |  |  |  |  |  |  |
|  | |  | |  |  | | |  | |  | |  |  |
|  | |  | |  |  | | |  | |  | |  |  |
| **Joint/Segment** | | **First Measurement** | |  | **Second Measurement** | | | | | **ROM** | |  |  |
|  | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Left Wrist** | |  |  |  |  |  |  |  |  |  |  |  |  |
|  | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Right Wrist** | |  |  |  |  |  |  |  |  |  |  |  |  |
|  | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Left Knee** | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Lying on Back** | |  |  |  |  |  |  |  |  |  |  |  |  |
|  | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Right Knee** | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Lying on Back** | |  |  |  |  |  |  |  |  |  |  |  |  |
|  | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Left Knee** | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Lying on Stomach** | |  |  |  |  |  |  |  |  |  |  |  |  |
|  | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Right Knee** | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Lying on Stomach** | |  |  |  |  |  |  |  |  |  |  |  |  |
|  | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Head** | |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Remember to note any discomfort or pain**

**Analyze the data you collected.**

How does the injured side differ from the unaffected side?

Report your findings to Dr. Shelley.