



HealthRite

Physical & Occupational Therapy Rehab Clinic
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Info@healthriteclinic.com Email

Patient Name: _____ D.O. B: _____
Phone: _____ Date of Injury: _____ Date of Surgery: _____
Diagnosis: _____
ICD-10 Codes: _____
Insurance _____ ID Number: _____

EVALUATION&TREATMENT

Physical Therapy

Occupational Therapy

FREQUENCY OF TREATMENT

DURATION OF TREATMENT

1 2 3 4 5 Visits/Week

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TREATMENT AREAS

- Cervical Thoracic Lumbar Sacrum
- Shoulder (R)(L) (BL) Elbow(R)(L) (BL) Wrist (R)(L) (BL) Hand(R)(L) (BL)
- Hip (R)(L) (BL) Knee(R)(L)(BL) Ankle (R)(L)(BL) Foot (R)(L)(BL)

MODALITIES

- Hot/Cold Pack Ultrasound Cold Laser Electrical Stimulation
- Iontophoresis Microcurrent Paraffin Bath

THERAPEUTIC PROCEDURE

- Therapeutic Exercise Therapeutic Activities ADL Exercise
- Neuromuscular Education Manual Therapy Gait training
- Sensory Reeducation Kinesio-Taping Home Exercise Program
- Edema Management Scar Management Wound Care

HAND THERAPY

- PROM AROM AAROM Nerve Gliding
- Splinting: Custom Splinting Pre-fabricated Splinting
- Static Splinting Dynamic Splinting

RETURN TO WORK PROGRAM

- Functional Capacity Evaluation Work Conditioning/Hardening Program
- Body Mechanic Training Postural Awareness

ASSESSMENT

- Wheelchair Assessment Home Modification Assessment

Special Instructions or Precautions: _____

Physician Printed Name: _____ Phone Number: _____

Physician Signature: _____ Date: _____

Fax: _____ NPI Number: _____