NA'AU PONO
PHYSICAL THERAPY

- Private _____
- No Fault Treatment Plan
- Workers Compensation Treatment Plan

Patient's Name _____ Date of Birth _____

Patient's Contact Number _____ Date of Injury/Surgery _____

ICD-9/ICD-10 _____ Diagnosis _____

ICD-9/ICD-10 _____ Diagnosis _____

Precautions _____

OUR SERVICES

Physical Therapy

_____ x per week for _____ weeks.

TOTAL

Work Hardening & Conditioning

_____ x per week for _____ weeks.

TOTAL

Evaluate and Treat

Manual Therapy
Joint Mobilization
Manual Traction
Myofascial Release
Strain-Counterstrain

Modalities
Mechanical Traction
Electrical Stimulation
Ultrasound

Therapeutic Exercises
Home Exercise Program
Postural Education/ Ergonomics
Strengthening

Neuromuscular Re-Ed
CVA/ Stroke Recovery
Coordination/ Proprioception

Other

_____

_____

Physician's Signature _____ **Date** _____

Physician's Name (printed) _____ Phone _____ Fax _____

FOR OFFICE USE ONLY

Treatment plan start date _____ End date _____ Estimated Cost $ _____

Company _____ Employer _____

Adjuster _____ Ph _____ Fax _____

Claim No. _____ Approved _____ Denied _____

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