Treatment Plan

Treatment Plan for: _____ Date: _____

Limitations of activities of daily living:

Treatment plan discussed with Client:
Yes No

Clients Goal / Treatment Goal:

Received informed consent for treatment plan:
Yes No

Type / Focus of Treatment:

Frequency: _____ Duration: _____

Areas to be treated:

Back	Arm	L	R	Chest
Neck	Leg	L	R	Breast
Shoulders	Gluteus			Other (list)
Face	Abdominals			

Assessments Performed:

Anticipated Progression of Responses:

Results of Assessments:

Remedial exercises recommended:

Reassessment Schedule:

Contraindications / Risks:

Referrals: