



THERAPRACTICS KNEE RE-EVAL

PATIENT: _____ DATE: _____

PATIENT #: _____ EMPLOYER: _____

DIAGNOSIS: _____ PHYSICIAN: _____

GENERAL COMMENTS

Pain level & % improvement: _____

Since the Initial Eval. on _____ / Re-Eval. on _____ the patient has had _____ treatments.

The patient's physical therapy treatment program has consisted of: Ther. Exs. STM Jt. Mobs. IFC

U.S. Iontophoresis Other: _____

The patient has had a total of _____ treatments since the Initial Evaluation.

ASSESSMENT / OBJECTIVE PALPATION: _____

Range of Motion:	RIGHT	LEFT
Straight Leg Raise (SLR)	°	°
Knee Motion 0 - 145° (Active/Passive)	/	/
Strength: Psoas	/5	/5
Flexion	/5	/5
Extension	/5	/5
Girth:		
" Above Suprapatellar Border		
Mid Patellar Border		
" Below Infrapatellar Border		

SUMMARY: The patient has made Good Fair Poor progress in physical therapy.

Additional comments: _____

Recommend that the patient be Discharged to a H.E.P. Continue with the following treatment plan:

Treatment Plan: Ther. Exs. STM Jt. Mobs. IFC U.S. Iontophoresis Other: _____

Frequency: _____ x/wk. Duration: _____ wks.

R.P.T., D.C.