Comprehensive Physical Therapy Care Plan

Patient Information

Patient Name: [Patient Name]

Date of Birth: [DOB]

Medical Record Number: [MRN]

Date of Evaluation: [Date]

Referring Physician

Name: [Physician Name]

Contact Information: [Phone/Email]

Diagnosis

[Diagnosis Description]

Objectives

- [Objective 1]
- [Objective 2]
- [Objective 3]

Interventions

- [Intervention 1]
- [Intervention 2]
- [Intervention 3]

Frequency and Duration

[Frequency of Visits] - [Duration of Treatment]

Goals

Short-term Goals:

- [Short-term Goal 1]
- [Short-term Goal 2]

Long-term Goals:

- [Long-term Goal 1]
- [Long-term Goal 2]

Plan for Review

[Review Date - Include Guidelines for Assessing Progress]

Therapist Signature

[Therapist Name]

[Credentials]

[Date]