

WHAT ARE WE GOING TO DO?

TREATMENT PLAN



Name _____

(Last)

(First)

(Middle)

Date _____ Phone # _____

Address _____

ICE: TO REDUCE SWELLING AND DISCOMFORT

When: AM PM **How Long:** _____ x Per Day _____ Minutes

What part(s) of the body: _____

Additional Comments: _____

ADJUSTMENTS: TO REALIGN THE SPINE

To Reduce: Nerve Pressure

Desired Result: Regain full, unrestricted motion Slow arthritic change

Restore even weight distribution Stabilize problem area Other

Additional Comments: _____

REHABILITATION: TO STRENGTHEN AND STABILIZE

1. Flexibility: _____

2. Endurance: _____

3. Strength: _____

Additional Comments: _____