

# 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: \_\_\_\_\_