



# Rehab Professionals of Cleveland, Inc.

*Relieving your pain. Restoring your active lifestyle.*

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Patient \_\_\_\_\_

Diagnosis \_\_\_\_\_ ICD Code \_\_\_\_\_

Precautions \_\_\_\_\_

## Physical Therapy

### Goals

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Improve Strength | <input type="checkbox"/> Reduce Pain             | <input type="checkbox"/> Improve Endurance |
| <input type="checkbox"/> Improve Posture  | <input type="checkbox"/> Improve Range of Motion | <input type="checkbox"/> Other             |

### Please Evaluate and Treat with the Following Recommendations

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Therapeutic Exercise    | <input type="checkbox"/> Aquatic Exercise            | <input type="checkbox"/> AlterG Anti-Gravity Treadmill |
| <input type="checkbox"/> Joint Mobilization      | <input type="checkbox"/> Dynamic Trunk Stabilization | <input type="checkbox"/> Balance Training              |
| <input type="checkbox"/> TMJ Dysfunction Program | <input type="checkbox"/> Gait Analysis/Training      | <input type="checkbox"/> Neuromuscular Re Education    |
| <input type="checkbox"/> FCE                     | <input type="checkbox"/> Headache Program            | <input type="checkbox"/> Osteoporosis Program          |
| <input type="checkbox"/> Work Conditioning       | <input type="checkbox"/> Sports Performance Program  |  |

### Special Instructions

### Frequency and Duration

\_\_\_\_\_ times a week/month for \_\_\_\_\_ weeks/months

Therapist's Discretion

Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_