Prescription – Knee Pain Assessment

Patient name_____ Date of birth_____

Diagnosis_____ Precautions_____

☐ Physical therapy ☐ Occupational therapy

beaumont.org/knee-pain-therapy

☐ **Evaluate, develop and implement a plan of care**

☐ manual therapy	☐ self care	☐ core strengthening
☐ therapeutic exercise	☐ activities of daily living	☐ core stabilization
☐ neuromuscular re-education	☐ home management training	☐ home exercise program
☐ therapeutic activities	☐ patient education/counseling	☐ modality procedures

Frequency: _____ x per week Duration: _____ weeks

_____	_____	_____
Physician's printed name	Physician's signature	Date

I certify that I have examined the patient and physical or occupational therapy is necessary and the services will be furnished while the patient is under my care.

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