STEPHAN J. SWEET, M.D., M.P.H.
A Professional Corporation
Sports Medicine, Arthroscopy, & General Orthopedic Surgery

PHYSICAL THERAPY PRESCRIPTION

DIAGNOSIS: (LEFT/ RIGHT) **DATE__________________**

HIP PHYSICAL THERAPY PRESCRIPTION

___ Ice/ Massage /Anti-Inflammatory Modalities

___ Range of Motion Active/ Active-Assisted/ Passive

___ Active Release Therapy/ Manual Therapy
___ Gluteus Maximus/ Iliopsoas /Adductor /Abductor Functional Assessment/
Stretching/ Strengthening
___ Quadriceps and Hamstring stretching
___ Quadriceps Strengthening ___V.M.O. Strengthening
___ Full Arc ___0-30° Arc
___ Hamstring Strengthening
___ Iliotibial Band Stretching/ Strengthening
___ Straight Leg Raises/ Quad Isometrics
___ Exercise Bike ___ Stair climber ___ Cybex
___ Hydrotherapy

Treatment: __________ times per week **__________Home Program**

Duration: __________weeks

**Please send progress notes.

Physician's Signature:____
Stephan J. Sweet, M.D., M.P.H.

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