PHYSICAL THERAPY PRESCRIPTION

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Keck Medicine of USC

PATIENT STICKER

DATE: _____

DIAGNOSIS: (LEFT/RIGHT) _____

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 ___ Stairclimber ___ Cybex

___ Hydrotherapy

Treatment: _____ times per week **___ Home Program**

Duration: _____ weeks

**Please send progress notes.

Physician's Signature: _____
Frank Petrigliano, MD, Attending Orthopaedic Surgeon, USC