Bounce
PHYSICAL THERAPY
FOR KIDS

4205 Longbranch Road ● Liverpool, NY 13090 ● Phone: 315-214-3431 ● Fax 457-0430

Name:	DOB:	Date:
Visit #: 01		Progress Summary: N/A
Physician: Dr.		
Diagnosis: Gait Abnormality, Generalized weakness		

PHYSICAL THERAPY EVALUATION

Assessment	Long-Term Goals
_____presents with gait abnormality characterized by intoeing, lack of push off/third rocker and with falls on uneven ground. Regarding standing posture and LE alignment, he presents with head tilt L, patellae facing lateral to the frontal plane, B genu varum with L genu recurvatum and medial arch collapse of both feet. He prefers to play in w-sitting or full squat. Forefoot adduction is 0 degrees B; normal for his age. He has increased medial tib-fib rotation compared to femoral alignment at the knee. LE alignment and play seated in long sitting or ring sitting improved with elastic wraps to support medial tib-fib alignment. Parents were taught the same for HEP. Soft tissue mobility was decreased in ITB, calf and low back. Strength of core: 3/5, hip extension: 3/5, calf 2/5. He has good potential to improve safety with walking and LE alignment to age expectation with PT and progressive HEP.	(4 weeks) 1.) I of caregivers with home program for strengthening and mobilizing trunk flexion, trunk rotation, hip adduction and calf through play positioning. 2.) I with safe walking, without falls outdoors x 30 minutes of play. 3.) Strength improve to 4/5 in trunk flexors, calf and hip extension. 4.) I with play out of squat or w-sitting 50% of a 30 minute play time at home, per family.

Treatment Plan: Sessions x 10 for strengthening and mobilizing trunk flexion, trunk rotation, hip adduction and calf through play positioning. Tape for abdominals and medial tib-fib rotation and STR PRN. Progressive HEP and family education.

Thank you for this referral. If you have any questions about this patient, please call our office.
Provider: _____ Date: _____
Crystal A. Duda, MSPT Lic.# 020377

I certify that the above rehabilitative services are required and authorized by me.

Physician: _____ Date: _____
Changes to above treatment plan:

PLEASE SIGN AND FAX BACK TO : 315- 457-0430