Bounce
PHYSICAL THERAPY
FOR KIDS

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

Name:	DOB:	Date:
Visit #: 1		Progress Summary: n/a
Physician:		Diagnosis: Neck Pain, Torticollis, plagiocephaly

Assessment	Long-Term Goals
_____ presents with decreased mobility within cervical spine and B shoulder girdles limiting ROM with R rotation and L SB. She demonstrates very mild L plagiocephaly. Her ROM is characterized as full and preferred with L rotation and side bent R. Sidebending R is full with ear approximating shoulder, and L is to midline plus 10 degrees, with end range pain response. Home program has begun for R cervical rotation and L sidebending, bid. It also includes strategies to progress midline head control in supine, sidelying and prone. Vision and UE use appear WNL for her chronologic age. She has good potential to gain full and symmetric cervical ROM and progress with timely developmental gross motor skills through physical therapy with progressive home program. A barrier to progress is considerable reflux signs and symptoms. Her home program was adjusted to accommodate this.	(4 weeks) 1.) I of caregivers with home program for cervical SB L and rotation R. 2.) Improve cervical rotation B to 85 degrees, without end range head tilt or pain response. 3.) Improve cervical SB B to 60 degrees without end range pain response. 4.) Improve supine with head in midline to independent during full spinal flexion including chin tuck. 5.) Improve midline head and hands orientation to independent on R and L sides for 30 seconds. 6.) Improve prone on elbows to independent and with equal weight through B shoulder girdles for 30 seconds while watching toys and faces.

Treatment Plan: Sessions 1-2 times per week for manual soft tissue release and AAROM for SB B and rotation B, strengthening of cervical spine and B shoulder girdles in a symmetric manner through developmental positioning and assisted transitions, progressive home program and caregiver 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