

## PT Session Treatment Form – Manipulation Program

(This form is appropriate for patients in the Manipulation + Exercise group, Sessions 1-2.)

**Subject ID:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_ **Treating Therapist:** \_\_\_\_\_  
mm dd yy

**Co-interventions used?** yes  no  **If yes, describe:** \_\_\_\_\_

**Treatment Group:**     **Manipulation + Exercise Group Only**

<b>Manipulation + Exercise Treatment Program</b>			
<b>Manipulation Attempt</b>	<b>Side Manipulated</b>	<b>Cavitation ?</b>	<b>Comments</b>
<b>1.</b>	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(if yes, proceed to ROM exercise)</i>	
<b>2.</b>	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(if yes, proceed to ROM exercise)</i>	
<b>3.</b>	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(if yes, proceed to ROM exercise)</i>	
<b>4.</b>	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(if yes, proceed to ROM exercise)</i>	
<b>ROM Exercise</b>	<b>Included in Program</b>	<b>Repetitions</b>	<b>Comments</b>
Supine Pelvic Tilts	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(if no, indicate reason in the comments)</i>		