

**CANBY**

365 South Redwood St  
Canby, OR 97013  
**Ph: 503.651.2020**  
Fax: 503.651.2019

**CLACKAMAS**

9100 SE Sunnyside Rd  
Clackamas, OR 97015  
**Ph: 503.305.6129**  
Fax: 503.305.5950

**LAKE OSWEGO**

101 S. State Street, Suite 4200  
Lake Oswego, OR 97034  
**Ph: 503.636.3028**  
Fax: 503.636.1837

**MILWAUKIE**

4606 SE Boardman  
Milwaukie, OR 97267  
**Ph: 503.353.9776**  
Fax: 503.353.9777

**OREGON CITY**

1715 S Beavercreek Road  
Oregon City, OR 97045  
**Ph: 503.657.8553**  
Fax: 503.557.0490

**PORTLAND - AIRPORT**

5847 NE 122nd Street, Suite 101  
Portland, OR 97230  
**Ph: 503.252.2556**  
Fax: 503.252.2584

**PORTLAND - HOLLYWOOD**  
*Formerly Black Diamond PT*

4224 NE Halsey Street, Suite 340  
Portland, OR 97213  
**Ph: 503.288.4643**  
Fax: 503.208.7016

**PORTLAND - NORTHEAST**

332 NE San Rafael Street  
Portland, OR 97212  
**Ph: 503.288.2615**  
Fax: 503.288.0339

**PORTLAND - PEARL DISTRICT**

1622 NW 15th Ave.  
Portland, OR 97209  
**Ph: 503.222.4640**  
Fax: 503.222.2730

**ST. HELENS**

021 Cowlitz St  
St. Helens, OR 97051  
**Ph: 503.396.5410**  
Fax: 503.396.5411

**TIGARD**

15755 SW Sequoia Pkwy., Suite 101  
Tigard, OR 97224  
**Ph: 503.639.8284**  
Fax: 503.624.7216



**NORTH LAKE**  
*Physical Therapy  
and Rehabilitation*

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Phone: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Dx: \_\_\_\_\_

Precautions: \_\_\_\_\_

**Treatment Schedule:**

Frequency: \_\_\_\_\_ x/week      Duration (# of weeks): \_\_\_\_\_

**Goals & Objectives:**

- ↑Strength & ROM       ↓Pain       Improve Function       Patient Education
- Other \_\_\_\_\_

**EVALUATE AND TREAT**

- ROM/Stretching       Cold Laser       Incontinence/Pelvic Floor
- Strengthening       Electrical Stimulation       Hand Therapy/Splinting
- Massage/Mobilization       Ice/Heat       Aquatic Therapy  
*(Oregon City, Milwaukie, Clackamas)*
- Back/Neck Care       ASTYM
- Traction       Orthotic Evaluation
- Ultrasound       Fall Risk Assessment

**SPORT SPECIFIC EVALUATION:**

- Bike Fit       Running       Golfing       Other \_\_\_\_\_

**PREHAB:** \_\_\_\_\_

*I hereby certify that the above services have been deemed medically necessary.*

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Printed Name: \_\_\_\_\_

*Please include a copy of the surgery or imaging report if appropriate.*



# **NORTH LAKE** *Physical Therapy and Rehabilitation*

[WWW.NORTHLAKEPT.COM](http://WWW.NORTHLAKEPT.COM)



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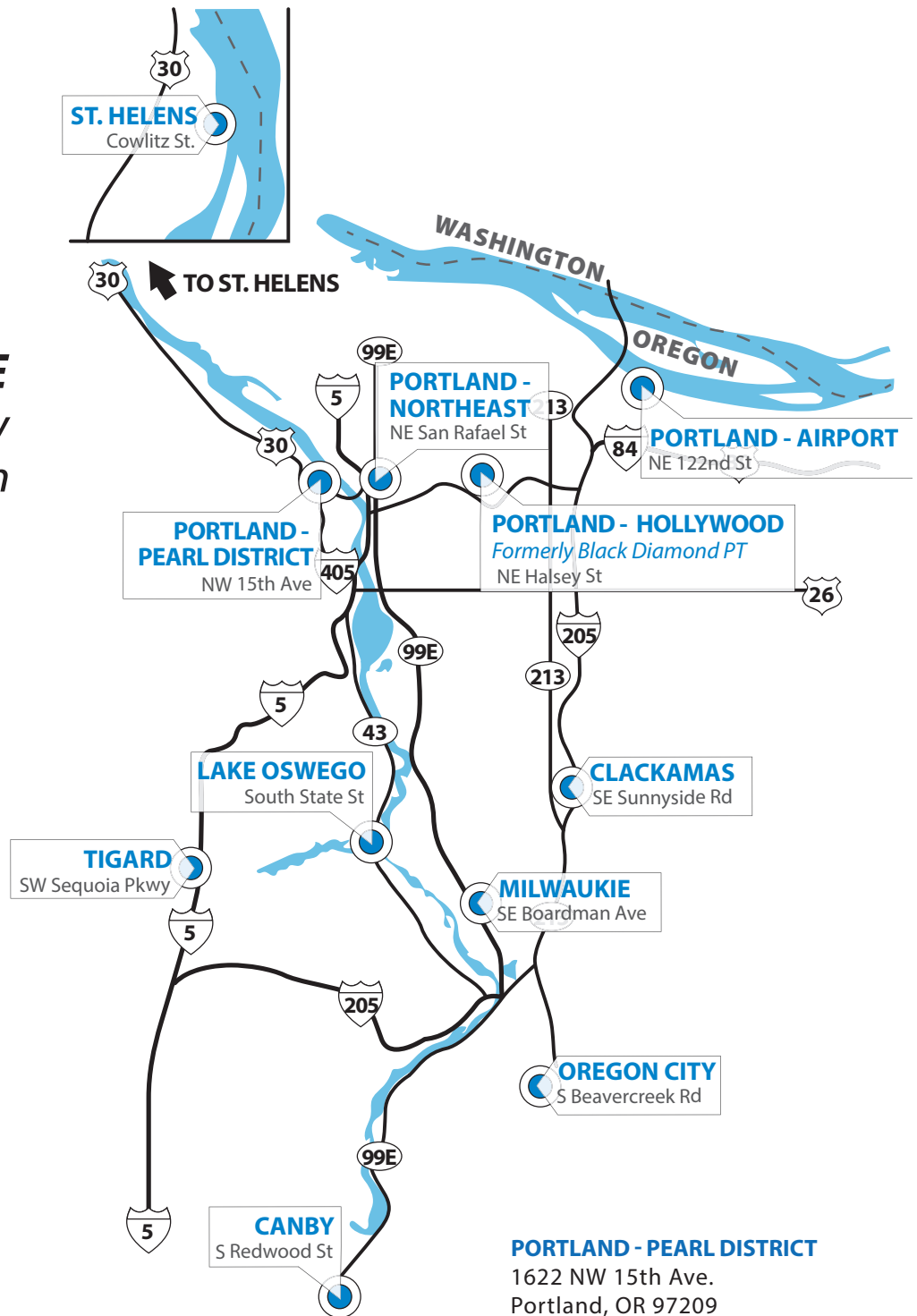
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