PATIENT'S NAME: ______________________ PATIENT'S PHONE: ______________

DIAGNOSIS: ______________________ DOB: ______________

PRECAUTIONS: ______________________

PHYSICAL THERAPY

- ☐ **Evaluate and Treat**
- ☐ Therapeutic Exercise (Active, Passive, PRE)
- ☐ Functional Activities (Gait, Balance, ADL)
- ☐ Neuromuscular Re-education
- ☐ Manual Therapy (Joint & Soft Tissue Mobilization)
- ☐ Modalities (Elect Stim, Ultrasound, Iontophoresis)
- ☐ Thermal Modalities (Ice, Moist Heat)
- ☐ Traction (Lumbar, Cervical)
- ☐ Comments: ______________________

SPECIALTY PROGRAMS

- ☐ ACTIVITY PRESCRIPTION PROGRAM
  - General Exercise for Health / Disease Prevention
  - Oncology / Cancer Conditioning
  - Diabetes Management through Activity
- ☐ ARTHRITIS / PREHABILITATION PROGRAM
- ☐ BALANCE / FALL PREVENTION
- ☐ CARDIOPULMONARY PHYSICAL THERAPY
- ☐ DIABETIC PERIPHERAL NEUROPATHY
- ☐ LOW BACK AND NECK PAIN
- ☐ OSTEOPOROSIS PROGRAM
- ☐ POST-MASTECTOMY CARE
- ☐ POST-SURGICAL CARE
- ☐ PRENATAL PROGRAMS
  - Carpal Tunnel Syndrome
  - Low Back / Pelvic Pain
- ☐ TMJ / HEADACHE PROGRAM
- ☐ VESTIBULAR REHABILITATION
- ☐ WORK INJURY / RETURN TO WORK
- ☐ OTHER: ______________

Comments / Parameters: ______________________

Frequency: ________ times per week for _____ weeks. Signature: ______________ Date: ____________

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