

PRESCRIPTION FOR PHYSICAL THERAPY

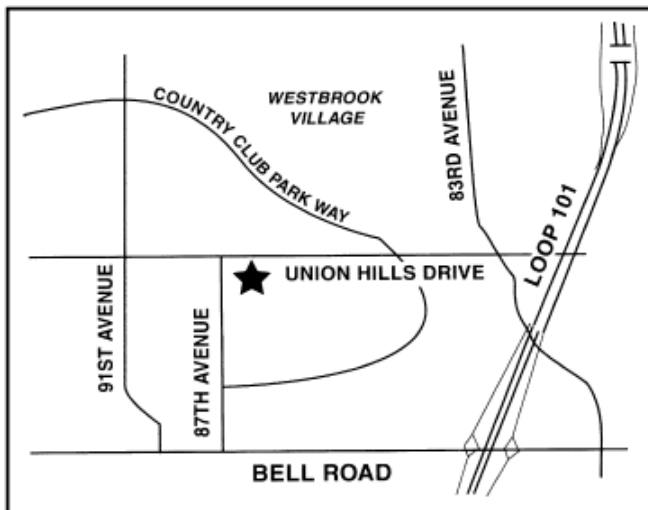
Patient Name: _____ **Date:** _____

Diagnosis: _____

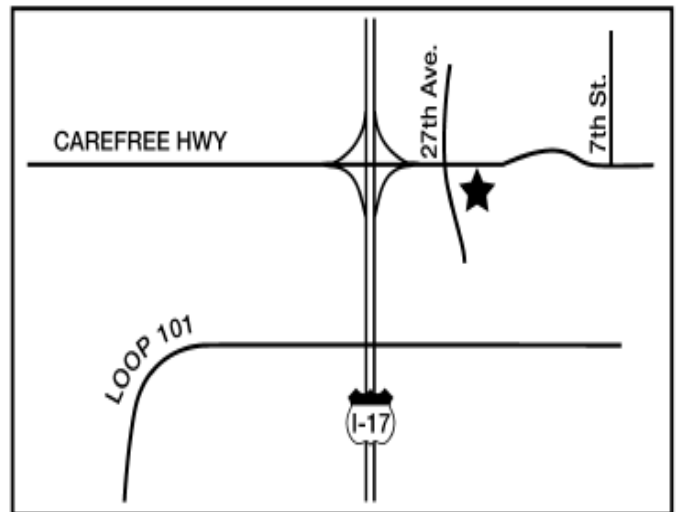
- | | |
|--|---|
| <input type="checkbox"/> Evaluate and RX
<input type="checkbox"/> Modalities as Indicated
<input type="checkbox"/> Therapeutic Exercise
<input type="checkbox"/> Joint/Soft Tissue Mobilization
<input type="checkbox"/> Vestibular/Vertigo
<input type="checkbox"/> Home Exercise Program
<input type="checkbox"/> Fitness Consultation | <input type="checkbox"/> Pelvic Floor Eval and Treat
<input type="checkbox"/> Custom Orthotics
<input type="checkbox"/> ASTYM
<input type="checkbox"/> Dry Needling
<input type="checkbox"/> Kinesio-Taping
<input type="checkbox"/> Gait/Running Video Analysis |
|--|---|

Comments:

_____ **Times/Wk/For** _____ **Wks** **Physicians Signature:** _____



Union Hills and 87th Avenue in Peoria



I-17 and Carefree Highway in Phoenix