Name: ______________________________ DOB: ______________

Date: ______________________________ Dx Code: ______________

Diagnosis: ____

____

Surgical Procedure: ____________________ Onset Date: ____________

Precautions: ____

TREATMENT:

- Evaluate and Treat
- Home Exercise Program
- Manual Therapy
- Gait Training
- ROM active passive
- Strengthening / PRE's
- Spine Rehab
- Ultrasound
- Electrical Stimulation
- Traction
- Kinesiotaping
- Posture / Body Mechanics
- Total Joint Rehab
- Vestibular / Balance Program
- Protocol ________________
- Dry Needling
- Pre & Post Op Surgical Rehabilitation
- Vertigo / Dizziness
- Other ___________________

Physician Name (Print): ______________________________

Physician Signature: ______________________________

Phone #: ____________________ Fax #: ____________________

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