PHYSICAL THERAPY ♦ WELLNESS SERVICES ♦ PAIN MANAGEMENT ♦ SPORTS ENHANCEMENT

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Name ______________________________ Date ____________

Diagnosis ____

Medical Precautions ______________________________________

Date of Onset/Surgery _____________________________________

1 2 3 4 5 times/week ________ weeks ________ as needed

☐ **EVALUATE AND TREAT**

OR

☐ **MANUAL THERAPY**
- ☐ PROM
- ☐ Joint Mobilization
- ☐ Soft Tissue Massage
- ☐ Myofascial Release
- ☐ PNF
- ☐ Traction
- ☐ Instrumentation / ASTYM

☐ **FDN** (Functional Dry Needling)

☐ **EXERCISE**
- ☐ Home Exercise Program
- ☐ Strength Training
- ☐ Flexibility
- ☐ Postural/Core Stability
- ☐ Plyometrics
- ☐ Balance Training
- ☐ Sports Performance
- ☐ Running Gait Evaluation
- ☐ As per Protocol

☐ **MODALITIES**
- ☐ NMES
- ☐ IFC
- ☐ TENS
- ☐ Mechanical Traction
- ☐ Iontophoresis
- ☐ Ultrasound
- ☐ Kinesio / McConnell Taping

☐ **OTHER** __________________
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I hereby certify these services as medically necessary for patient's plan of care.

Physician's Signature _______________________________________ Date: ____________________

Print Name ____