



# Prescription for Physical Therapy

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Name of Physician: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ /20\_\_\_\_

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

Diagnosis: \_\_\_\_\_

Primary: \_\_\_\_\_ Area: \_\_\_\_\_

Secondary: \_\_\_\_\_ Area: \_\_\_\_\_

Additional Dx: \_\_\_\_\_ Area: \_\_\_\_\_

Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

### Evaluate and treat:

#### PROCEDURES:

- Therapeutic Procedure/Exercise
- Therapeutic Activities
- Joint Mobilization/Manual Therapy
- Myofascial Release
- Manual Traction
- Soft Tissue Mobilization
- Neuromuscular Reeducation
- Gait Training
- Taping
- Home Exercise Program
- Other: \_\_\_\_\_

#### MODALITIES:

- Ultrasound
- IFC Electrical Stimulation
- Moist Heat
- Ice Pack
- Iontophoresis
- Phonophoresis
- Infared/Light Therapy
- Other: \_\_\_\_\_

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