



# movement for life physical therapy

treatment  
referral

PATIENT'S NAME: ..... PATIENT'S PHONE: .....

DIAGNOSIS: ..... DOB: .....

PRECAUTIONS: .....

## physical therapy

- Evaluate & Treat**
  - Modalities (E-stim, Ice, Moist Heat)
  - Traction (Lumbar, Cervical)
- Therapeutic Exercise (Active, Passive, PRE)
- Functional Activities (Gait, Balance, ADL)
- Neuromuscular Re-education
- Manual Therapy (Joint & Soft Tissue Mobilization)

## specialty programs

- Activity Prescription Program
- Arthritis/Prehabilitation Program
- Balance/Fall Prevention
- Blood Flow Restriction (BFR)
- Cardiopulmonary Physical Therapy
- Diabetic Peripheral Neuropathy
- Hand Therapy Specialty
- 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

Comments / Parameters: .....

Frequency: ..... times per week for ..... weeks. Signature: ..... Date: .....

# the experts in movement



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## santa maria

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[movementforlife.com](https://www.movementforlife.com)