



movement for life physical therapy

treatment
referral

PATIENT'S NAME: PATIENT'S PHONE:

DIAGNOSIS: DOB:

PRECAUTIONS:

physical therapy

- Evaluate & Treat**
- Therapeutic Exercise**
(Active, Passive, PRE)
- Functional Activities**
(Gait, Balance, ADL)
- Neuromuscular Re-education**
- Manual Therapy**
(Joint & Soft Tissue Mobilization)
- Modalities**
(Elect Stim, Ultrasound, Iontophoresis)
- Thermal Modalities**
(Ice, Moist Heat)
- Traction** (Lumbar, Cervical)
- Comments:**
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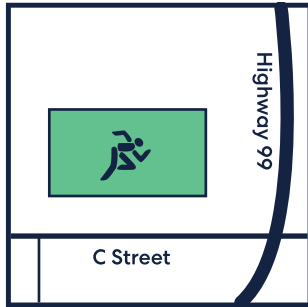
specialty programs

- ACL Injury Prevention
- Arthritis/Prehabilitation Program
- Balance/Fall Prevention
- Blood Flow Restriction (BFR)
- Cardiopulmonary Physical Therapy
- Concussions
- Diabetes Management
- Osteoporosis Program
- Post-surgical Care
- Postural Program
- Strength-Training Program
- TMJ/Headache Program
- Vestibular Rehabilitation
- Weight Loss Prescription
(Weight Loss Coaching, Fitness Training)
- Work Injury/Return To Work
- Other

Comments / Parameters:

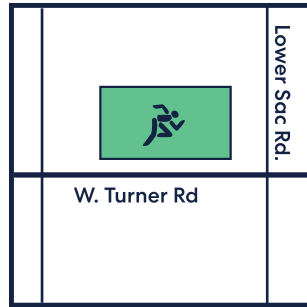
Frequency: times per week for weeks. Signature: Date:

the experts in movement



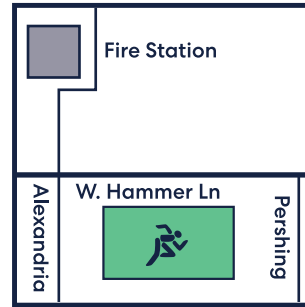
galt

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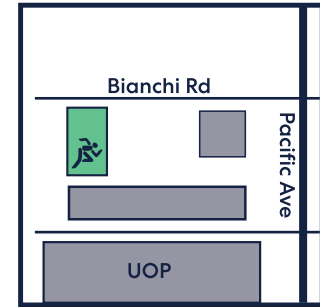
lodi

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