

Patient: _____ DOB: _____

Diagnosis: _____

Precautions: _____

Frequency: _____ times/week Duration: _____ weeks

■ Evaluate & Treat

Therapeutic Exercise

- ROM (P, A/A, A)
- Flexibility
- Strengthening
- Stabilization
- Postural Training
- Body Mechanics
- Gait Training
- Balance/Proprioception

Modalities

- Moist Heat
- Ultrasound
- Electrical Stimulation
- Iontophoresis
- Biofeedback
- Traction: Cervical/Lumbar

Manual Therapy

- Joint Mobilization
- Myofascial Release
- Soft Tissue Mobilization
- Muscle Energy Technique
- Manual Traction

Work Conditioning

Neuromuscular Re-Ed

Vestibular Rehab

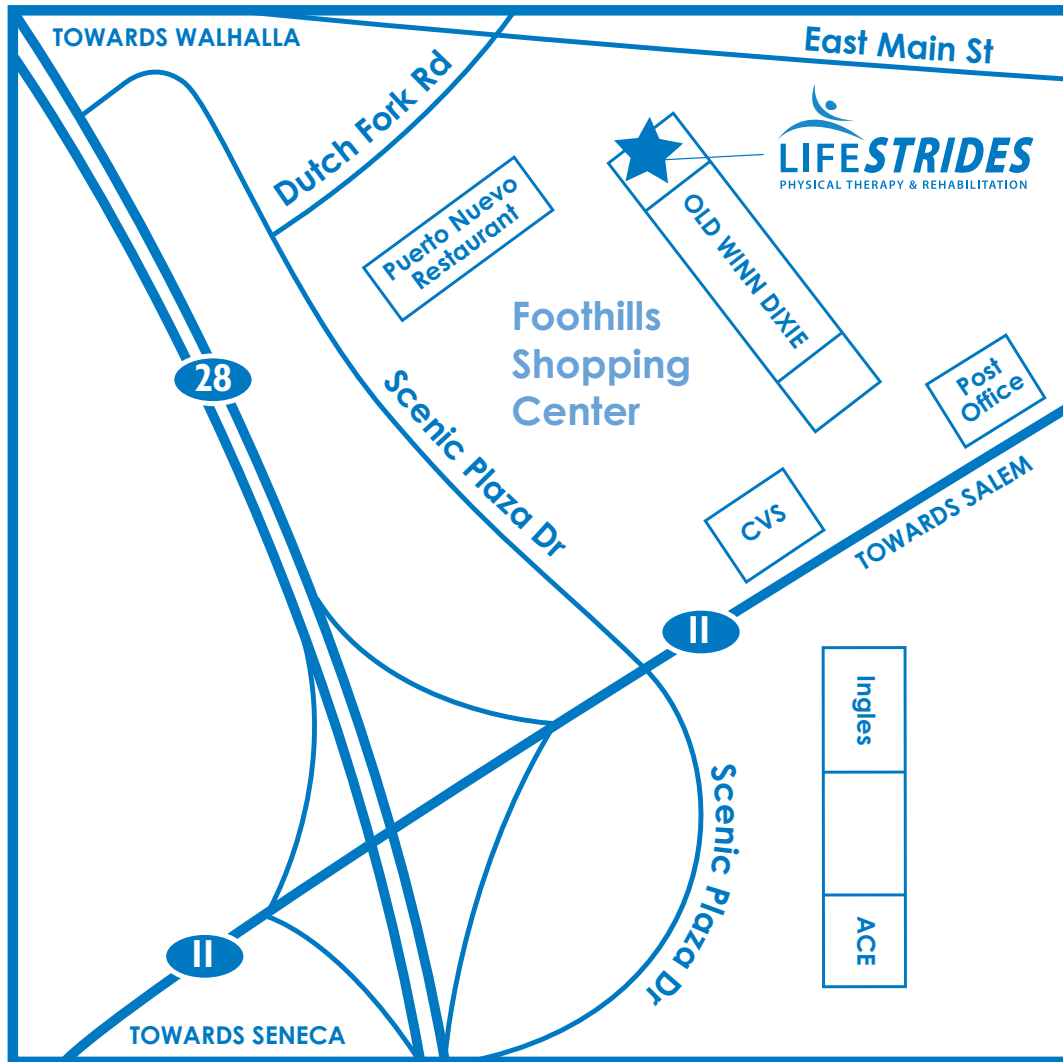
Sport Specific Training: _____

Other: _____

Special Instructions: _____

I certify that the above ordered treatment for therapy is medically necessary.

Signature: _____ Date: _____



**Located off Highways 28 and 11 in the Foothills Shopping Center,
near Puerto Nuevo Restaurant**

JUST A REMINDER:

Please bring this referral slip with you on your first visit.

Please arrive 15 minutes before your scheduled appointment to complete the necessary paperwork.

Evaluations (1st visit) usually last 1 to 2 hours.

WHAT TO WEAR:

Please wear/bring comfortable clothing (e.g. T-shirt, shorts, or sweatpants) and sneakers.