Patient Name: ___________________________ Date: __________________________

☐ Call patient to schedule appointment Phone: __________________________

Diagnosis: ____________________________________________

ICD10 Codes: __________________________________________

Comments / Precautions: __________________________________________

__________________________

☐ Evaluate and treat per therapy evaluation

☐ Frequency _______ x per week x _______ weeks Total Visits: ____________

Treatments:

☐ Joint Mobilization/Manipulation
☐ Soft Tissue Mobilization/Manipulation
☐ Therapeutic Exercise (STEP)
☐ Proprioceptive Training
☐ Neuromuscular Education
☐ Sports Specific Rehab
☐ Spinal Stabilization Programs
☐ Acute Injury Post MVA (3-5 days)
☐ Cervical-oculomotor Neuromuscular Training

☐ Myofascial Release
☐ Scar Tissue Mobilization/Manipulation
☐ Cranial-Sacral Therapy
☐ Visceral Mobilization
☐ Temporomandibular Dysfunction
☐ Chronic Pain Syndromes
☐ Pilates
☐ Other: __________________________

Modalities:

☐ Frequency Specific Microcurrent
☐ Other: __________________________

Physicians’s Name (please print) ___________________________ Date: ____________

Physician’s Signature: ___________________________ Date: ____________

Physician’s Clinic Phone: ___________________________