Therapy Excellence

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*Click on the new patient tab to print your intake paperwork prior to the first visit*

## PHYSICAL THERAPY PRESCRIPTION

Patient Name:_____ Date: _____
Patient Phone:_____ Alternate Phone:_____
Region/Diagnosis:_____ Surgery: _____
Physician (Printed):_____ Signature: _____
Frequency: □ 1 wk □ 2x wk □ 3x wk □ Daily Duration: _____ weeks

□ **Evaluate and Treat**
□ Home Exercise Program
□ Manual Therapy
□ Strengthening
□ Modalities
  □ PRN
  □ Mechanical Traction
  □ _____
□ Other _____
□ Special Instructions:

□ Range of Motion
  □ PROM ONLY
  □ AAROM
  □ AROM
  □ Limits: _____
□ Dry Needling
□ Gait Training
  □ _____WB
  □ WBAT
  □ FWB

_____

_____