



PATIENT'S NAME: _____ PATIENT'S PHONE: _____

DIAGNOSIS: _____

PRECAUTIONS: _____

PHYSICAL THERAPY

- Evaluate and 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: _____

SPECIALTY PROGRAMS

- ACTIVITY PRESCRIPTION PROGRAM
 - General Exercise for Health / Disease Prevention
 - Oncology / Cancer Conditioning
 - Diabetes Management through Activity
- ARTHRITIS / PREHABILITATION PROGRAM
- BALANCE / FALL PREVENTION
- CARDIOPULMONARY PHYSICAL THERAPY
- DIABETIC PERIPHERAL NEUROPATHY / ANODYNE
- FOOT / ANKLE TREATMENT PROGRAM
- OSTEOPOROSIS PROGRAM
- POST MASTECTOMY CARE
- POST-SURGICAL CARE
- PRENATAL PROGRAMS
 - Carpal Tunnel Syndrome
 - Low Back / Pelvic Pain
 - Prenatal Massage (Oro Valley)
- TMJ / HEADACHE PROGRAM
- VESTIBULAR REHABILITATION
- WOMEN'S HEALTH (Tanque Verde)
 - Incontinence
 - Pregnancy / Post Partum
- WORK INJURY / RETURN TO WORK
- OTHER _____

Comments / Parameters: _____

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