



# movement for life

## physical therapy

treatment  
referral

PATIENT'S NAME: ..... PATIENT'S PHONE: .....

DIAGNOSIS: ..... DOB: .....

PRECAUTIONS: .....

### physical therapy

- ☐ **Evaluate & Treat**
  - ☐ Modalities (E-stim, Ice, Moist Heat)
- ☐ Therapeutic Exercise (Active, Passive, PRE)
  - ☐ Traction (Lumbar, Cervical)
- ☐ Functional Activities (Gait, Balance, ADL)
- ☐ Neuromuscular Re-education
- ☐ Manual Therapy (Joint & Soft Tissue Mobilization)

### specialty programs

- ☐ Activity Prescription Program
- ☐ Arthritis/Prehabilitation Program
- ☐ Balance/Fall Prevention
- ☐ Blood Flow Restriction (BFR)
- ☐ Cardiopulmonary Physical Therapy
- ☐ Diabetic Peripheral Neuropathy
- ☐ Hand Therapy Specialty
- ☐ Low Back and Neck Pain
- ☐ Osteoporosis Program
- ☐ Post-Mastectomy Care
- ☐ Post-surgical Care
- ☐ Prenatal Programs (Carpal Tunnel Syndrome, Low Back/Pelvic Pain)
- ☐ TMJ/Headache Program
- ☐ Vestibular Rehabilitation
- ☐ Work Injury/Return To Work

Comments / Parameters: .....

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

# the experts in **movement**



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**movementforlife.com**