



PATIENT'S NAME: PATIENT'S PHONE:

DIAGNOSIS: DOB:

PRECAUTIONS:

physical therapy

- | | |
|---|--|
| <input type="checkbox"/> Evaluate & Treat | <input type="checkbox"/> Modalities
(Elect Stim, Ultrasound,
Iontophoresis) |
| <input type="checkbox"/> Therapeutic Exercise
(Active, Passive, PRE) | |
| <input type="checkbox"/> Functional Activities
(Gait, Balance, ADL) | <input type="checkbox"/> Thermal Modalities
(Ice, Moist Heat) |
| <input type="checkbox"/> Neuromuscular
Re-education | <input type="checkbox"/> Traction (Lumbar, Cervical) |
| <input type="checkbox"/> Manual Therapy
(Joint & Soft Tissue
Mobilization) | <input type="checkbox"/> Comments: |

specialty programs

- | | |
|--|---|
| <input type="checkbox"/> ACL Injury Prevention | <input type="checkbox"/> Post-surgical Care |
| <input type="checkbox"/> Arthritis/Prehabilitation Program | <input type="checkbox"/> Postural Program |
| <input type="checkbox"/> Balance/Fall Prevention | <input type="checkbox"/> Strength-Training Program |
| <input type="checkbox"/> Blood Flow Restriction (BFR) | <input type="checkbox"/> TMJ/Headache Program |
| <input type="checkbox"/> Cardiopulmonary Physical Therapy | <input type="checkbox"/> Vestibular Rehabilitation |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Weight Loss Prescription
(Weight Loss Coaching, Fitness Training) |
| <input type="checkbox"/> Diabetes Management | <input type="checkbox"/> Work Injury/Return To Work |
| <input type="checkbox"/> Osteoporosis Program | <input type="checkbox"/> Other |

Comments / Parameters:

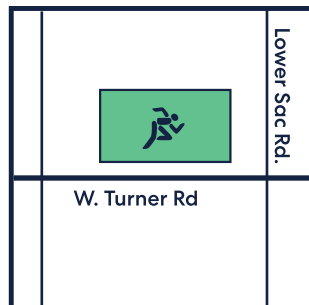
Frequency: times per week for weeks. Signature: Date:

the experts in movement



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