movement for life
physical therapy

treatment referral

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

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

PRECAUTIONS: .....

physical therapy

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

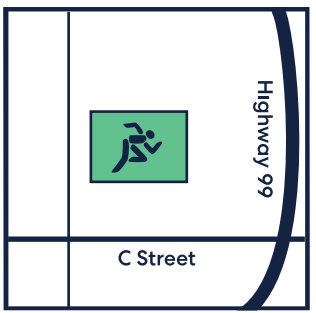
specialty programs

- ☐ ACL Injury Prevention
- ☐ Arthritis/Prehabilitation Program
- ☐ Balance/Fall Prevention
- ☐ Blood Flow Restriction (BFR)
- ☐ Concussions
- ☐ Hand Therapy
- ☐ Pelvic Floor Rehabilitation
- ☐ Post-surgical Care
- ☐ Postural Program
- ☐ Strength-Training Program
- ☐ TMJ/Headache Program
- ☐ Vestibular Rehabilitation
- ☐ Weight Loss Prescription (Weight Loss Coaching, Fitness Training)
- ☐ Work Injury/Return To Work

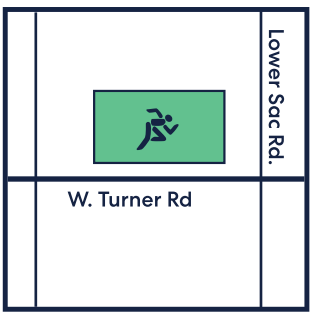
Comments / Parameters: .....

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

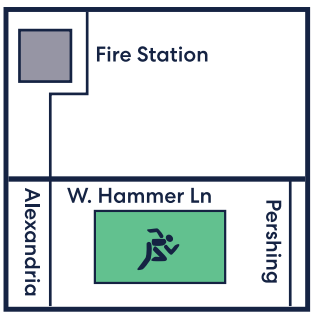
the experts in movement



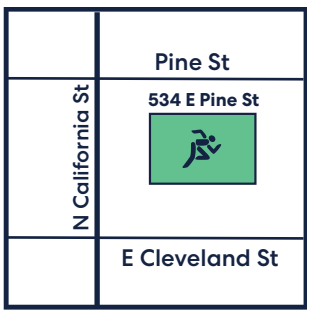
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movementforlife.com