

5546 S. Fort Apache Road. #100B
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Premier Physical Therapy & Sports Performance

www.premierphysicaltherapy.com

Date: _____ Pt. Name: _____

Pt. DOB: _____ Pt. Phone #: _____

Diagnosis: _____

Referring Physician: _____

Evaluate & Treat

- Neck Back Shoulder Wrist/Hand Hip Knee Ankle/Foot

Functional Programs/Procedures:

- | | |
|---|---|
| <input type="checkbox"/> Pain Management | <input type="checkbox"/> Range of Motion |
| <input type="checkbox"/> Manual Therapy | <input type="checkbox"/> Joint Mobilization |
| <input type="checkbox"/> McKenzie Program | <input type="checkbox"/> Therapeutic Exercise |
| <input type="checkbox"/> Posture/Body Mechanics Training | <input type="checkbox"/> Functional Strength Training |
| <input type="checkbox"/> Home Exercise Program/Patient Education | <input type="checkbox"/> Functional Mobility Training |
| <input type="checkbox"/> Work Conditioning/Work Hardening | <input type="checkbox"/> Proprioceptive Training |
| <input type="checkbox"/> Functional Restoration Program | <input type="checkbox"/> Core/Lumbar Stabilization |
| <input type="checkbox"/> Pain Education Program | <input type="checkbox"/> Vestibular Balance Therapy |
| <input type="checkbox"/> Corrective Exercise Program | <input type="checkbox"/> Soft Tissue Mobilization |
| <input type="checkbox"/> Osteoporosis Program/Power Plate Training | <input type="checkbox"/> Strain-Counterstrain |
| <input type="checkbox"/> Injury Prevention/Kinetic Chain Assessment | <input type="checkbox"/> Myofascial Release |
| <input type="checkbox"/> Performance Enhancement/Return to Sport | <input type="checkbox"/> Other: _____ |

Modalities:

- | | | |
|--|---|---|
| <input type="checkbox"/> Electrotherapy (TENS/IFC) | <input type="checkbox"/> Biofeedback/NMES | <input type="checkbox"/> Moist Heat |
| <input type="checkbox"/> Cryotherapy | <input type="checkbox"/> Paraffin | <input type="checkbox"/> Contrast Bath |
| <input type="checkbox"/> Ultrasound/Phonophoresis | <input type="checkbox"/> Iontophoresis | <input type="checkbox"/> Infrared Light Therapy |

Frequency _____ x week Duration _____ weeks

Physician Signature: _____

The above treatment program is approved and considered medically necessary



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