



OUTPATIENT REHABILITATION SCRIPT

1890 West County Road 419 • Suite 1000 • Oviedo, Florida 32765
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PATIENT NAME: _____ PATIENT PHONE: _____

DIAGNOSIS

NECK / BACK / PELVIC PAIN

- | | | |
|---|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Stenosis | <input type="checkbox"/> Sacroiliac Dysfunction |
| <input type="checkbox"/> Cervical / Thoracic Pain | <input type="checkbox"/> Thoracic Outlet Syndrome | <input type="checkbox"/> Intervertebral Disc Injury |
| <input type="checkbox"/> TMJ Dysfunction | <input type="checkbox"/> Rib Pain / Restriction | |

EXTREMITY PAIN / DISORDERS: **RIGHT** **LEFT**

- | | | |
|--|--|--|
| <input type="checkbox"/> Shoulder / Elbow / Wrist Pain | <input type="checkbox"/> Hip / Knee Pain | <input type="checkbox"/> Ankle / Foot Pain |
| <input type="checkbox"/> Shoulder Bursitis | <input type="checkbox"/> Hip Bursitis | <input type="checkbox"/> Ankle Sprain |
| <input type="checkbox"/> Nerve Entrapment | <input type="checkbox"/> Piriformis Syndrome | <input type="checkbox"/> Ankle Strain |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Plantar Faciitis |

BALANCE / SAFETY

- | | | |
|---|--|--|
| <input type="checkbox"/> Ataxia | <input type="checkbox"/> Parkinsons | <input type="checkbox"/> Vestibular / BPPV |
| <input type="checkbox"/> CVA / TIA / TBI | <input type="checkbox"/> Peripheral Neuropathy | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Gait Abnormality | | |

POST-SURGICAL CONDITIONS: **RIGHT** **LEFT** **DATE OF SURGERY:** _____

- | | | |
|---|--|---|
| <input type="checkbox"/> Total Shoulder Replacement | <input type="checkbox"/> Total Hip Replacement | <input type="checkbox"/> Total Knee Replacement |
| <input type="checkbox"/> Rotator Cuff / Labrum Repair | <input type="checkbox"/> Spinal Fusion | <input type="checkbox"/> ACL / Meniscus Repair |
| <input type="checkbox"/> Carpal Tunnel Repair | <input type="checkbox"/> Laminectomy | |

Contraindications / Precautions / Restrictions: _____

OTHER DIAGNOSIS / POST-SURGICAL CONDITION: _____

- | | | |
|--|--|--|
| <input type="checkbox"/> Physical Therapy
Evaluation & Tx | <input type="checkbox"/> Occupational Therapy
Evaluation & Tx | <input type="checkbox"/> Speech Therapy
Evaluation & Tx |
|--|--|--|

OTHER: _____

I certify that this treatment is medically necessary

PHYSICIAN / ARNP / PA NAME: _____

PHYSICIAN / ARNP / PA SIGNATURE: _____ DATE: _____



NIRVANA
SPORTS MEDICINE & REHABILITATION SERVICES

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