



Name _____ Date _____

D.O.B. _____ Home Phone _____

Diagnosis _____

Precautions _____

Frequency _____

Evaluate and Treat as Indicated Modalities/Excercises as Indicated

Home Exercise Program

TENS/E-stim

Strengthening

Iontophoresis

Balance/ Coordination

Ultrasound/Phonophoresis

PROM/AAROM/AROM

Traction

Gait Training

Fluidotherapy

Manual Therapy

Women's health

Pediatric

Biofeedback Vaginal Stim

Work Related Rehabilitation

Work Hardening

Functional Capacity Testing

Ergonomics Consultation

Reconditioning

Specific Recommendations: _____

_____ M.D. Name

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