



Premier™

Physical Therapy & Wellness

Prescription for Physical Therapy

PATIENT'S NAME: _____ DATE _____

DIAGNOSIS: _____

EVALUATE AND TREAT

- | | |
|--|--|
| <input type="checkbox"/> Hand Therapy | <input type="checkbox"/> Moist Heat |
| <input type="checkbox"/> Lumbar Stabilization Exercises
Extension Based Program | <input type="checkbox"/> Cryotherapy/ ICE |
| Flexion Based Program | <input type="checkbox"/> Electrical Stimulation |
| <input type="checkbox"/> Pediatric Physical Therapy | <input type="checkbox"/> Neuromuscular Electrical
Stimulation |
| <input type="checkbox"/> TMJ Program | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Vestibular Rehabilitation | <input type="checkbox"/> Phonophoresis with _____ |
| <input type="checkbox"/> PROM | <input type="checkbox"/> Iontophoresis with _____ |
| <input type="checkbox"/> AAROM | <input type="checkbox"/> Traction |
| <input type="checkbox"/> AROM | <input type="checkbox"/> Paraffin |
| <input type="checkbox"/> Strengthening | <input type="checkbox"/> Low Level Laser Therapy |
| <input type="checkbox"/> Therapeutic Exercise | <input type="checkbox"/> Taping |
| <input type="checkbox"/> Neuromuscular Re-education | <input type="checkbox"/> Orthotics |
| <input type="checkbox"/> Flexibility/ Stretching | <input type="checkbox"/> Brace _____ |
| <input type="checkbox"/> Joint Mobilization | <input type="checkbox"/> Work Hardening Program |
| <input type="checkbox"/> Myofascial Release/ Massage | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Gait Training | |
| <input type="checkbox"/> Balance Training | |
| <input type="checkbox"/> Posture/Body Mechanics | |

PRECAUTIONS	GOALS/COMMENTS
FREQUENCY	DURATION

PHYSICIAN NAME (Print): _____ Date _____

PHYSICIAN SIGNATURE: _____



PremierTM

Physical Therapy & Wellness

New York City

Upper East Side @ 77th

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