MUSCLE&SPINE
REHABILITATION CENTER

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Patient Name: ______________________ Telephone: ______________________

Diagnosis: ______________________ ICD 9/ICD 10 Code: ______________________

Insurance: ______________________ Precautions: ______________________

Physician Follow-up date: ____________ ______________________

Physical Therapy Services

☐ Evaluate and Treat ☐ Modify as Needed ☐ Continue Physical Therapy

Treatment Focus

☐ Lumbar Stabilization
☐ Cervicogenic Headache
☐ Temporomandibular Dysfunction
☐ Vestibular/Balance Disorder
☐ Post Surgical Rehab
☐ Shoulder Dysfunction
☐ Functional Capacity Exam (FCE)
☐ Work Hardening/Conditioning

Therapeutic Exercise

☐ Range of Motion
☐ Strengthening
☐ Back School
☐ Home Program
☐ Unweighting System

Manual Therapy

☐ Myofascial Therapy
☐ Strain & Counterstrain
☐ Joint Mobilization/Manipulation
☐ ASTYM
☐ Therapeutic Massage

Modalities

☐ Electrical Stimulation
☐ Ultrasound
☐ Iontophoresis
☐ Traction
☐ Whirlpool
☐ TENS
☐ Cold Laser

Special Instructions: ______________________________

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Frequency:

__________ Times per week for

Duration:

__________ weeks

☐ At Therapist Discretion

Rehab Appointment:

Date: ______________________

Time: ______________________

I certify that the above patient is under my care, has been seen within the last 30 days and this prescription is medically necessary.

Physician Signature ______________________ **Date** ______________________