in-teg-ri-ty
Physical Therapy and Wellness

511 North Main, Carroll, Iowa 51401

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Physical Therapy Treatment Prescription

Patient: ______________________________

Address: ______________________________

Phone no. ______________ Date of Birth: ______________

Medical diagnosis related to treatment:

1 ______________________________

2 ______________________________

3 ______________________________

____ Evaluation and Treatment
____ Home Program/ Education
____ Therapeutic Exercise
____ Manual Therapy
____ Soft Tissue Mobilization
____ Joint Mobilization
____ Traction (Mechanical)
____ Infrared Light Therapy
____ Functional Capacity
____ Work Hardening & Conditioning
____ TMJ assessment
____ Neuromuscular Facilitation
____ Gait Training
____ Electrical Stimulation
____ Iontophoresis
____ TENS
____ Ultrasound
____ Transfer Training
____ Functional Activities
____ Pre-op program
____ Vestibular assessment
____ Other ______________

Comments: ______________________________

Frequency and Duration: ______________________________

Physician Signature: ______________________ Date: ______________

Physician Name: ______________________________

Address: ______________________________

City/State: ______________ **Phone:** ______________