



# INTEGRITY

PHYSICAL THERAPY AND WELLNESS

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## Physical Therapy Treatment Prescription

**Patient:** \_\_\_\_\_

**Date of birth:** \_\_\_\_\_

**Medical diagnosis related to treatment:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Evaluation & 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 & Duration:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Physician Name: \_\_\_\_\_ Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Phone: \_\_\_\_\_