Date: ____________________

Patient Name: _______________________________ DOB: _______________________

Home Number: _____________________ Cell Number: _________________________

ICD Code/Diagnosis: ____

Referring Physician: ____

Referring Physician Signature: ____

Physical Therapy Services and Treatment

☐ Initial Evaluation ☐ Hot/Cold Pack ☐ Electrical Stimulation ☐ Laser

☐ Ultrasound/Phonophoresis ☐ Traction ☐ Physical Therapy Exercise

☐ Manual Therapy ☐ Gait Training ☐ Therapeutic Activity ☐ Balance/Coordination

Comments: ____

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