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Fax Patient Information & RX to

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NAME:		DOB://	
DIAGNOSIS:		DATE OF	INJURY:/
			ITMENT://
FREQUENCY:	DURATION:		
PRECAUTIONS:			
TREATMENT	PLAN	PROCEDUR	RES
EVALUATE AND TREAT BACK PROGRAM SHOULDER PROGRAM CERVICAL PROGRAM TMJ PROGRAM	KNEE PROGRAM WRIST PROGRAM WORK CONDITIONING BALANCE DISORDER HAND PROGRAM	MODALITIES ELECTRICAL STIM TRACTION IONTOPHORESIS HOME EXER PROG	THERAPEUTIC EXERCISE STABILIZATION MOBILIZATION MYO-FASCIAL RELEASE GENERAL CONDITIONING
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□ Weight Loss/Gain□ Dyslipidemia□ Diabetes□ COPD	□ Fatigue□ Obesity□ Hypertension□ Coronary Heart Disease	□ Nutritional Guidance□ Increased Movement□ Managing Stress□ Balancing Hormones	□ Physical Activity□ Strength Training□ Customized Meal Plans□ Hydration
OTHER/SPECIAL INSTRU	JCTIONS		
PHYSICIAN:			
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