Smith Physical Therapy
& Wellness

Patient Name: ______________________________ DOB: ______________

Diagnosis: ____

Visits per week: ☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x

Number of weeks: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other:______________

Precautions: ____

☐ **Evaluate & Treat Per Therapist Discretion**

Rehabilitation Programs

- ☐ Ankle Rehabilitation
- ☐ Back Rehabilitation
- ☐ Elbow Rehabilitation
- ☐ Hip Rehabilitation
- ☐ Knee Rehabilitation
- ☐ Neck Rehabilitation
- ☐ Shoulder Rehabilitation
- ☐ Wrist & Hand Rehabilitation

Special Programs

- ☐ Balance & Gait Training
- ☐ General Strengthening
- ☐ Neurological Conditions
- ☐ Pelvic Floor Dysfunction
- ☐ Postural/Stabilization
- ☐ Pregnancy (Pre/Post Natal Care)
- ☐ Vestibular Rehabilitation

Modalities

- ☐ Dry Needling
- ☐ Electrical Stimulation
- ☐ Hot/Cold Packs
- ☐ Paraffin Bath
- ☐ Traction (Lumbar & Cervical)
- ☐ Ultrasound
- ☐ Vasopneumatic Device

Manual Therapy

- ☐ Myofascial Release
- ☐ Soft Tissue Mobilization
- ☐ Joint Mobilization

Other

- ☐ Kinesio/McConnell Taping
- ☐ Home Program
- ☐ ______________________

The below physician certifies that the prescribed rehabilitation is medically necessary for this patient's plan of care.

Referring Physician: ____________________________ Date: ______________

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