HealthQuest
PHYSICAL THERAPY

Patient's Name: _____ **DOB:**_____

Diagnosis: _____

Frequency:_____**times/week for** _____**weeks** **Account#:**_____

PHYSICAL THERAPY PRESCRIPTION

☑ **EVALUATE AND TREAT**

THERAPEUTIC EXERCISE
- ☐ Abdominal/Pelvic Stabilization (OMPT)
- ☐ AROM
- ☐ Cervical Strengthening/Stretching
- ☐ Home Exercise Program
- ☐ Isometric Exercise
- ☐ Isotonic Exercise
- ☐ Lumbar Strengthening/Stretching
- ☐ McKenzie Spine Program
- ☐ Stretching Exercise

NEUROMUSCULAR RE-EDUCATION
- ☐ Balance & Proprioceptive Training
- ☐ Biofeedback
- ☐ Gait Training
- ☐ Joint Strapping
- ☐ Kinesio/Rock Taping
- ☐ Lifting Techniques
- ☐ Proper Body Mechanics & Posture

THERAPEUTIC ACTIVITIES
- ☐ Dynamic Activities
- ☐ Functional Performance
  - ☐ Reaching/Lifting
  - ☐ Squatting/Lifting

MODALITIES
- ☐ Electrical Stimulation
- ☐ Ice
- ☐ Iontophoresis
- ☐ Moist Heat
- ☐ Ultrasound

MANUAL THERAPY
- ☐ Instrument Assisted Soft Tissue Mobilization/Graston®
- ☐ Joint Mobilization
- ☐ Manual/Mechanical Traction
- ☐ PNF/Manual Resistance
- ☐ Soft Tissue Mobilization

SPECIALTIES
- ☐ Aquatic Therapy (New Baltimore)
- ☐ Blood Flow Restriction
- ☐ Cupping
- ☐ Concussion Management
- ☐ Dry Needling
- ☐ Foot Orthotics
- ☐ Headaches/Migraines
- ☐ Overhead Athlete Rehab
- ☐ Parkinson's (LSVT - Big/Loud, PRW!)
- ☐ Pediatrics
- ☐ TMJ/TMD
- ☐ Vestibular Rehab
- ☐ Women's/Men's Health
  - ☐ Incontinence
  - ☐ Pelvic Floor

Special Instructions: _____

Dates to Cover: _____ **to** _____

Physician Name (please print): _____

Physician Signature: _____ **Date:**_____

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