

Patient Name: \_\_\_\_\_ Patients Phone: \_\_\_\_\_

Patients Insurance Plan: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

**CONDITIONS:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Neck Pain     | <input type="checkbox"/> Post Op Rehab  | <input type="checkbox"/> Difficulty Walking   |
| <input type="checkbox"/> Back Pain     | <input type="checkbox"/> Knee           | <input type="checkbox"/> Lack of Coordination |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Hip            | <input type="checkbox"/> Abnormal Gait        |
| <input type="checkbox"/> Hip Pain      | <input type="checkbox"/> Shoulder       | <input type="checkbox"/> Abnormal Posture     |
| <input type="checkbox"/> Knee Pain     | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> _____                |
| <input type="checkbox"/> Fibromyalgia  | <input type="checkbox"/> Osteoporosis   | <input type="checkbox"/> _____                |

**TREATMENT:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Evaluate & Treat     | <input type="checkbox"/> Soft Tissue Mobilization | <input type="checkbox"/> Ultrasound             |
| <input type="checkbox"/> Therapeutic Exercise | <input type="checkbox"/> Joint Mobilization       | <input type="checkbox"/> Electrical Stimulation |
| <input type="checkbox"/> Potural ReEducation  | <input type="checkbox"/> AROM/AAROM               | <input type="checkbox"/> Ice Pack/Cryotherapy   |
| <input type="checkbox"/> Gait Training        | <input type="checkbox"/> Passive ROM/Stretching   | <input type="checkbox"/> Hot Pack               |
| <input type="checkbox"/>                      |   |   |

**METABOLIC THERAPY:** (Check all that apply)

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Chronic Fatigue    | <input type="checkbox"/> Hypoglycemia             | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Insulin Resistance | <input type="checkbox"/> Hyperglycemia            | <input type="checkbox"/> Obesity      |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Dysmetabolic Syndrome    | <input type="checkbox"/> Weight Gain  |
| <input type="checkbox"/> Hyperlipidemia     | <input type="checkbox"/> Impaired Fasting Glucose | <input type="checkbox"/> _____        |

**Frequency:**    1    2    3    4    5    **Times Per Week**

**Duration:**    1    2    3    4    5    6    7    8    **Weeks**

**Comments/Precautions/Restrictions:** \_\_\_\_\_

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Physicians Name

Central Mesa  
303 N Centennial Way  
Mesa, AZ 85201

South East Mesa: Augusta Ranch  
2919 S Ellsworth Rd #115  
Mesa, AZ 85212

North East Mesa: Power/Brown  
6840 E Brown Rd Suit 104  
Mesa, AZ 85207