



MOTION SYNERGY PHYSICAL THERAPY, LLC

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TREATMENT PRESCRIPTION

Name _____

Phone _____ DOB _____

Diagnosis _____

Test/X-Ray Results _____

Precautions / Comments _____

Frequency/Duration _____ times / week or As Determined by Therapist

PHYSICAL THERAPY EVALUATE AND TREAT

- | | |
|---|--|
| <input type="checkbox"/> Therapeutic Exercise | <input type="checkbox"/> Strengthening / Stabilization |
| <input type="checkbox"/> Range of Motion | <input type="checkbox"/> Joint Mobilization / Manipulation |
| <input type="checkbox"/> Soft Tissue Mobilization | <input type="checkbox"/> Home Program |
| <input type="checkbox"/> Myofascial Release | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Cardiovascular Conditioning | <input type="checkbox"/> Posture Retraining |
| <input type="checkbox"/> Neuromuscular Re-Education | <input type="checkbox"/> Electrical Stimulation |
| <input type="checkbox"/> Iontophoresis with Dexamethasone | <input type="checkbox"/> Traction |
| <input type="checkbox"/> TMJ Program | <input type="checkbox"/> Vestibular Rehabilitation |

Other _____

Signature _____ Date _____

Please fax completed form to 730-9405 and/or give to the patient to bring to their initial appointment: Date _____ Time _____

(for map of MSPT location, see reverse side)