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

- ❏ Therapeutic Exercise
- ❏ Range of Motion
- ❏ Soft Tissue Mobilization
- ❏ Myofascial Release
- ❏ Cardiovascular Conditioning
- ❏ Neuromuscular Re-Education
- ❏ Iontophoresis with Dexamethasome
- ❏ TMJ Program
- ❏ Strengthening / Stabilization
- ❏ Joint Mobilization / Manipulation
- ❏ Home Program
- ❏ Ultrasound
- ❏ Posture Retraining
- ❏ Electrical Stimulation
- ❏ Traction
- ❏ Vestibular Rehabilitation

Other ____

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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)