



Physical Therapy

3515 Richmond Rd, Texarkana, TX

Phone: 903.831.5454

Fax: 903.791.0381

Patient Name: _____ DOB: _____

Diagnosis: _____

Frequency: _____/week Duration: _____/weeks

EVALUATE AND TREAT FOR PHYSICAL THERAPY

Please include the following:

- Back/Spine Education and Self Management
- Balance/Vestibular Rehabilitation
- Post-Op Specific Protocol
- Home Program
- Manual Therapy/Massage
- AROM/PROM
- Gait Training
- Cardiovascular Rehabilitation
- Modalities as Indicated
- Other:
- Orthotics/Equipement:

Precautions/Comments:

Physician Signature _____ Date _____