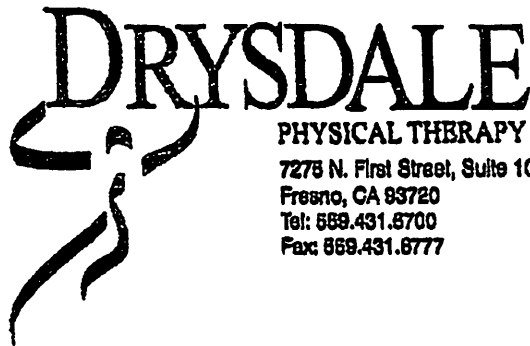




PHYSICAL THERAPY

7275 N. First Street, Suite 108
Fresno, CA 93720
Tel: 559.431.6700
Fax: 559.431.6777

Patient _____ Date _____

Medical Diagnosis _____

Date of Injury _____ Date of Surgery _____

Precautions / Contraindications _____

1 2 3 4 5 Times/Week _____ Week(s) _____ ☐ As Needed

EVALUATE AND TREAT

TREATMENT PRESCRIPTION

- ☐ Massage / Myofascial Release
- ☐ AROM / PROM
- ☐ Resistive / Strengthening
- ☐ Isometrics
- ☐ Gait / Balance Training
- ☐ Spinal Traction

MODALITIES & PROCEDURES

- ☐ Ultrasound
- ☐ Electrical Stimulation
- ☐ Paraffin Bath
- ☐ Phono / Iontophoresis
- ☒ Moist Heat / Cold Packs
- ☐ M-F Spray-Stretch

REHABILITATION PROGRAM

- | | | |
|--|---|--|
| ☐ Headache / Back Pain Relief | ☐ Shoulder Program | ☐ Hip Program |
| ☐ Back Program / McKenzie | ☐ Elbow Program | ☐ Knee Program |
| ☐ Sacroiliac Program | ☐ Wrist / Hand Program | ☐ Ankle Program |

Other _____

I hereby certify these services as medically necessary for the patient's plan of care.

Physician's Signature _____ Date _____

UPIN # _____