1717 N. Clyde Morris Blvd, Suite 140
Daytona Beach, FL 32117
PHONE: (386) 257-2672
FAX: (386) 252-1005
www.ThomasPhysicalTherapy.com

PATIENT NAME: _____

DIAGNOSIS: _____

SPECIAL INSTRUCTIONS or PRECAUTIONS: _____

☐ **Evaluate and Treat**

- ☐ Balance Disorder _____
  - ☐ Vertigo/Dizziness ☐ Unsteady Gait
- ☐ Upper Extremity Rehabilitation _____
  - ☐ Shoulder ☐ Elbow ☐ Hand/Wrist
- ☐ Lower extremity rehabilitation _____
  - ☐ Hip ☐ Knee ☐ Foot/Ankle
- ☐ Spinal Rehabilitation _____
  - ☐ Cervical ☐ Thoracic ☐ Lumbar
- ☐ Temporomandibular Rehabilitation _____
- ☐ Postural Improvement Program/Core Strengthening _____
- ☐ Spinal Stabilization Program _____
- ☐ Post-Operative Rehabilitation: _____
- ☐ Post Breast Cancer Treatment (scar tissue/range of motion) _____
- ☐ Osteoporosis Rehabilitation _____
- ☐ Adhesions/Scar Tissue Treatment: _____
- ☐ Strengthening and Conditioning Program _____
- ☐ Functional Training/Body Mechanics Training _____
- ☐ _____

THIS PHYSICAL THERAPY TREATMENT IS MEDICALLY NECESSARY. This treatment is in accord with standard medical practice to be effective for this patient's condition. The treatment is of complexity and sophistication that it must be performed by a physical therapist. Continuation of physical therapy will be determined based on the patient's progress and restoration potential.

DISCLAIMER: If the date below is left blank, we will consider the date we receive this prescription to be the date the patient was last seen.

_____ _____

Please Print Physician's Name Physician's Signature

_____ _____

Date Last Seen by Physician Date of Prescription