FYZICAL
Therapy & Balance Centers

Patient Name: ______________________________ Phone: ______________

Referring Physician: ______________________________ Date: ______________

Diagnosis: ____

Date of Surgery: ______________ Surgical Procedure: ______________________

Special Instructions: ______________________________________

❑ Evaluate & Treat ❑ Continue Current Rx

Frequency: ________ Visit(s) per Week Duration: ____________ Week(s)

Pre/Post-Op Rehab

- ❑ Knee
- ❑ Hip
- ❑ Back
- ❑ Shoulder
- ❑ Other:
- ❑ Neck
- ❑ Elbow
- ❑ Wrist/Hand
- ❑ Ankle/Foot

Balance Rehab

- ❑ Balance/Vestibular Therapy
- ❑ Canalith Repositioning
- ❑ Neurological Gait Training
- ❑ Other:

Orthopedic Rehab

- ❑ Strengthening
- ❑ Flexibility/R.O.M.
- ❑ Stabilization
- ❑ Soft Tissue Mobilization
- ❑ Joint Mobilization
- ❑ Other:

Programs

- ❑ Sports Specific
- ❑ FCE
- ❑ Work Conditioning
- ❑ Work Hardening
- ❑ Fitness
- ❑ Osteoporosis
- ❑ Fibromyalgia
- ❑ Neurological
- ❑ LVST BIG (Evans Crossing only)
- ❑ Other:

Modalities

- ❑ Ultrasound
- ❑ Electrical Stimulation
- ❑ Ionophoresis
- ❑ Traction
- ❑ Dry Needling (Boerne only)
- ❑ Laser (Boerne & South San Antonio only)
- ❑ Other:

Patient Education

- ❑ Balance/Vestibular
- ❑ Canalith Repositioning
- ❑ Neurological Gait Training
- ❑ Other:

Supplies

- ❑ Custom FootMaxx Orthotics
- ❑ Compression Stockings
- ❑ Braces
- ❑ Other:

Physician Signature: ______________________________ Date: ______________

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