

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 (Parkinson's)
(Boerne & Evans Crossings)
- 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: _____

COMING SOON!

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