



**FYZICAL Therapy &
Balance Centers of OKC**

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Special Instructions:

Frequency:

____ Days per Week

Duration:

____ Weeks/Months

Patient Name: _____ Phone: _____

Date of Birth: _____ Diagnosis: _____

Address: _____

OR ☐ Demographics Sheet Included

☐ **Evaluate & Treat**

Pre/Post-Op Rehabilitation

- | | |
|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Neck | <input type="checkbox"/> Back |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Wrist/Hand | <input type="checkbox"/> Ankle/Foot |

Patient Education

- ☐ Home Exercise Program
☐ Fall Prevention
☐ ADL Training
☐ Other: _____

Programs

- ☐ Balance Retraining
☐ Vestibular Therapy
☐ Headaches
☐ Osteoporosis
☐ Fibromyalgia
☐ S/P CVA
☐ Parkinsons
☐ Sports Specific
☐ Work Specific

Pelvic Floor Rehabilitation

- | | |
|---|---|
| <input type="checkbox"/> Constipation (K59.0) | <input type="checkbox"/> UII (N39.41) |
| <input type="checkbox"/> Hip Pain (M25.559) | <input type="checkbox"/> Prolapse (N81.9) |
| <input type="checkbox"/> Pubic Symphysis Pain (M25.559) | <input type="checkbox"/> Dyspareunia (N94.1) |
| <input type="checkbox"/> Coccyx Pain (M53.3) | <input type="checkbox"/> Vaginismus (N94.2) |
| <input type="checkbox"/> SIJ Dysfunction (M53.3) | <input type="checkbox"/> Vulvodynia (N94.89) |
| <input type="checkbox"/> Low Back Pain (M54.5) | <input type="checkbox"/> Urinary Frequency (R35.0) |
| <input type="checkbox"/> Diastasis (M62.0) | <input type="checkbox"/> Straining to Void (R39.16) |
| <input type="checkbox"/> Pelvic Floor Weakness (M62.5) | <input type="checkbox"/> Pelvic & Perineal Pain (R10.2) |
| <input type="checkbox"/> SUI (N39.3) | <input type="checkbox"/> Lower Abdominal Pain (R10.30) |
| <input type="checkbox"/> Voiding Dysfunction (N39.3) | |

☐ **Continue Current Rx**

Balance Rehabilitation

- ☐ Balance Retraining Therapy
☐ Canalith Repos. Maneuver
☐ Neurological Gait Training
☐ Concussion Management

Orthopedic Rehabilitation

- ☐ Strengthening
☐ Flexibility/ROM
☐ Stabilization
☐ Soft Tissue Mobilization
☐ Joint Mobilization
☐ Other: _____

Modalities

- ☐ Ultrasound
☐ Electrical Stimulation
☐ Iontophoresis
☐ Traction
☐ Other: _____

Physician Signature: _____ Date: _____

Physician Name (Printed): _____