FYZICAL®
Therapy & Balance Centers

Patient Name: _____ Phone: _____

Referring Physician: _____ Date: _____

Diagnosis: _____

Date of Surgery: _____ Surgical Procedure: _____

Special Instructions: _____

☐ Evaluate & Treat ☐ Continue RX

Frequency: _____ Visit(s) per Week Duration: _____ Weeks

Pre/Post-Op Rehab

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

Balance Rehab

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

Orthopedic Rehab

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

Programs

- ☐ Parkinson's Wellness Recover
- ☐ Sports Specific
- ☐ Work Conditioning
- ☐ Work Hardening
- ☐ Fitness
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ Neurological
- ☐ Other:

Modalities

- ☐ Ultrasound
- ☐ Electrical Stimulation
- ☐ Traction
- ☐ Solo Step Overhead Safety Rail System
- ☐ Shuttle Balance
- ☐ Other:

Patient Education

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

Physician Name: _____ Date: _____

Physician Signature: _____

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