**Visions At Home Physical Therapy**
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# Physical Therapy Prescription

Patient Name: _____ Date: _____

Physician: _____ Follow up date: _____

Diagnosis: _____ Date: _____

Precautions / Comments: _____

☐ Evaluate and Treat as Indicated

☐ Theraputic Exercise
- ☐ Range of Motion
- ☐ Balance Training
- ☐ Strengthening
- ☐ Gait Training
- ☐ Neuromuscular Re-Ed
- ☐ Transfer Training

☐ Modalities
- ☐ Hot Pack
- ☐ Cold Pack
- ☐ Iontophoresis
- ☐ Ultrasound
- ☐ Hivamat 200
- ☐ Interferential Current

☐ Manual Therapy
- ☐ PROM
- ☐ AAROM
- ☐ Soft Tissue Mobilization
- ☐ Spinal Mobilization
- ☐ Joint Mobilization
- ☐ Massage

☐ Medical Massage
- ☐ Myofascial Trigger Points
- ☐ Lower Back Pain
- ☐ Sciatica
- ☐ Neck Pain
- ☐ Carpal Tunnel Syndrome
- ☐ Tendonitis
- ☐ Muscle Spasticity
- ☐ Tennis Elbow
- ☐ Muscle Strains
- ☐ Ligament Sprains
- ☐ Peripheral Edema
- ☐ Rotator Cuff Syndrome
- ☐ Achilles Tendonitis
- ☐ Fibromialgia
- ☐ Tension Headaches
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Epicondilytis

Frequency: ☐ 2 ☐ 3 ☐ 4 ☐ 5 x per week  Duration: ☐ 2 ☐ 4 ☐ 6 ☐ 8 weeks

Physician's Signature: _____