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Physical Therapy Prescription

Patient Name: _____ Date: _____

Diagnosis: _____

Evaluate & Treat – please provide with home exercise program

ROM

PROM / AAROM / AROM

Restrictions: _____

Strengthening

Theraband Exercises

Core Strengthening

Closed Chain Quad Strengthening

No isokinetic exercises

Restrictions: _____

Modalities

Per therapist's discretion

Ultrasound

Iontophoresis

Electrical Stimulation

Work Conditioning

Functional Capacity Exam

Other: _____

Frequency: _____ x/week/month for _____ weeks/months

Signature: _____

Please fax all reports to 312-942-1517 at least 3 days prior to patient's next appointment.