PHYSICAL THERAPY Anderson Associates

Date:_____

Patient Name:_____ Date of Birth:_____

Phone Number:_____ Insurance Provider:_____

☐ Diagnosis:_____

☐ Patient is _____ weeks / months status post _____

ICD 10:_____

Area of Interest: Right / Left / Upper Extremity / Lower Extremity / Spine

Contraindication/Percautions:_____

Range of Motion: Passive / Active Assist / Active

☐ Evaluate and Treat	☐ Manual Therapy	☐ Ultrasound
☐ Pelvic Floor Rehabilitation	☐ Manual Traction	☐ Iontophoresis
☐ Gait Training	☐ Dry Needling	☐ Electrical Stimulation
☐ Vestibular Rehabilitation	☐ Joint Mobilization	☐ Mechanical Traction
☐ Neuromuscular Re-Education	☐ Myofascial Release	☐ Hot / Cold Pack
☐ Therapeutic Exercise		

Improve Gait and Balance / Improve Proprioception / Desensitization / Improve Strength

PHYSICIAN SIGNATURE:_____ Date:_____

Physician Name (Print):_____

Phone Number:_____ NPI:_____

Signature is confirmation that skilled physical therapy services are reasonable and medically necessary.

Phone
678-866-4104

Fax
678-668-7011