Westlake Physical Therapy, Inc.
Personalized care that gets you back to work and play.... *fast*

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Physical Therapy Prescription

Patient _____ Date _____

Diagnosis _____

Plan of Treatment / Recommendations

___ EVALUATION

Exercises
- ___ Active ROM
- ___ Active Assistive ROM
- ___ Passive ROM
- ___ Strengthening (PRE)
- ___ Williams Flexion Exercises
- ___ McKenzie Exercises
- ___ Spinal Stabilization
- ___ Muscle Re-Education
- ___ Patello - Femoral Program
- ___ Home Exercise Program

Traction
- ___ Cervical
- ___ Lumbar

Other
- ___ Joint Mobilization
- ___ Soft Tissue Mobilization
- ___ Massage
- ___ McConell Taping
- ___ TMJ Program
- ___ Dynasplint: _____
- ___ Lymphedema Treatment

___ EVALUATE AND TREAT

Rehabilitation
- ___ Neck
- ___ Shoulder
- ___ Elbow
- ___ Wrist
- ___ Hand
- ___ Back/Sacroiliac
- ___ Hip
- ___ Knee
- ___ Ankle
- ___ Foot
- ___ Stroke
- ___ Gait Training

Modalities
- ___ Ultrasound
- ___ Phonophoresis
- ___ Ice or Cold Packs
- ___ Hydrocollator Packs
- ___ Ionotophoresis
- ___ Contrast Bath
- ___ NMES
- ___ Interferential
- ___ TENS
- ___ Whirlpool
- ___ Paraffin Bath

Treatment Frequency: ___ BIW ___ TIW ___ QIW ___ Other: _____

Duration: _____ weeks (Therapy May include the above checked items.)

Comments: _____

Precautions: _____

PHYSICIAN'S SIGNATURE: _____

(I approve the above treatment.)