PHYSICAL THERAPY PRESCRIPTION

Patient Name: ____

Patient Date of Birth: ____

Diagnosis: ____

Date: ____

Goals of Rehabilitation to include:

_______ Improved Range of Motion
_______ Improved Gait
_______ Increased Strength
_______ Improved Motor Planning
_______ Improved Posture / Biomechanics
_______ Improved Functional Ability
_______ Improved Midline Orientation
_______ Improved Balance
_______ Establish / Upgrade Home Exercise Program

Frequency: ____________________________ Duration: _______________________________

Comments/Recommendations:
____
____
____
____
____

Physician Signature: ____

Physician Name: ____

Address: ____

Telephone #: ______________________________ **Fax #:** ___________________________

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