HENRY WONG
Physical Therapy and Wellness

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To schedule an appointment, please call: (415) 225-6652

Physical Therapy Prescription

Patient Name: _____DOB: _____

Patient Phone Number: _____

Physician: _____ Follow Up Date: _____

Diagnosis: _____

Date of injury/surgery: _____

Precautions/Comments: _____

_____

☐Evaluate & Treat as appropriate

☐Manual Therapy/Joint Mob
☐Soft tissue mobilization
☐Range of Motion (Passive / Active)
☐Strengthening/Conditioning
☐Therapeutic Exercise
☐Home Exercise Program
☐Kinetic/Therapeutic Activities
☐Neuromuscular Re-Ed (PNF)
☐Lumbar Stabilization Program
☐Core Muscle Strengthening
☐Body Mechanics Training
☐Postural Instruction/Education
☐Gait Training
☐Taping
☐Modalities
☐Hot and Cold Pack
☐Electrical Stimulation

☐**Frequency of Treatment:** _____ session/week, For _____ weeks

I hereby certify that Physical Therapy is medically necessary for this patient's plan of care.

_____ _____

Referring Physician's Signature **Date**