



MONTOYA

PHYSICAL THERAPY
AND WELLNESS

Patient Name: _____ DOB: _____

Physician: _____ Follow Up Date: _____

Diagnosis: _____

Frequency: _____ Duration: _____ No. of Visits: _____

Special Instructions: _____

PHYSICAL THERAPY:

- | | | |
|--|--|---|
| <input type="checkbox"/> Evaluate & Treat | <input type="checkbox"/> Home Exercise Program | <input type="checkbox"/> Spinal Stabilization |
| <input type="checkbox"/> Electric Muscle Stimulation | <input type="checkbox"/> Spinal Manipulation | <input type="checkbox"/> Neuromuscular re-education |
| <input type="checkbox"/> Heat/Cold Therapy | <input type="checkbox"/> Traction | <input type="checkbox"/> Gait Training |
| <input type="checkbox"/> Therapeutic Exercise | <input type="checkbox"/> Graston Technique | <input type="checkbox"/> Balance Therapy |

GOALS:

- Improve ROM Improve Strength Improve Mobility Improve Function

Other: _____

Physician Signature

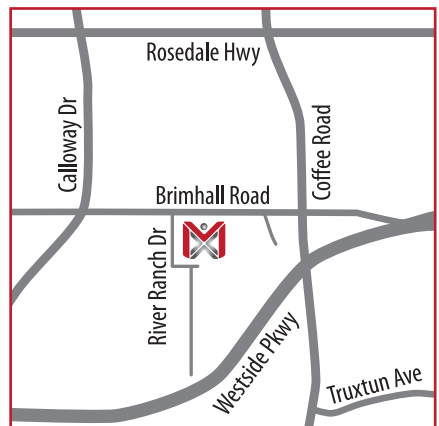
Date

Montoya Physical Therapy and Wellness

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MAP NOT TO SCALE