PEAK SPORT SPINE

PATIENT'S NAME: _____ RETURN TO DR. _____

DATE OF BIRTH: _____

HOME PHONE: _____ WORK/CELL _____

DIAGNOSIS: _____

☐ EVALUATE AND TREAT PER THERAPIST'S DISCRETION

MANUAL THERAPY

- ☐ Soft Tissue Mobilization
- ☐ Myofascial Release
- ☐ Joint Mobilization
- ☐ Manual Traction
- ☐ Additional:

_____

_____

EXERCISE

- ☐ Active/Passive/Resistive
- ☐ Neuromuscular Re-education
- ☐ Home Exercise Program
- ☐ ADL Training/Adaptive Equipment
- ☐ Isokenetic Testing: _____
- ☐ MedX:
  - __ Cervical (Columbia, Jefferson City)
  - __ Lumbar (Columbia, Jefferson City, Moberly)

MODALITIES AND PROCEDURES

- ☐ Electrical Stimulation
- ☐ Ultrasound
- ☐ Moist Heat/Cold Pack
- ☐ Iontophoresis/Phonophoresis
- ☐ Gait Training
- ☐ Compression Therapy
- ☐ Mechanical Traction

INDUSTRIAL REHABILITATION

- ☐ Work Conditioning
- ☐ Work Hardening
- ☐ Functional Capacity Evaluation
- ☐ Job Site Analysis
- ☐ Back School/Body Mechanics

PARAMETERS: _____

_____

_____

FREQUENCY: _____ DURATION _____

DATE: _____

PHYSICIAN SIGNATURE: _____

THANK YOU FOR YOUR REFERRAL!

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