H E A L T H B R I D G E

www.healthbridgechiro.com

❑ **Center City** p: (215) 546-0100 a: 1420 Locust St., Ste. 220, Philadelphia, PA 19102
❑ **Elkins Park** p: (215) 782-1394 a: 928 Township Line Road, Elkins Park, PA19027
❑ **Mt. Airy** p: (267) 672-1260 a: 1909 E. Washington Lane, Philadelphia, PA 19138
❑ **Juniata Park** p: (267) 672-1262 a: 1216 E. Hunting Park Ave., Philadelphia,PA 19124
❑ **West Phila.** p: (267) 292-9200 a: 6648 Lansdowne Ave., Philadelphia,PA 19151

THERAPY ORDERS

❑ CHIROPRACTIC ❑ THERAPEUTIC EXERCISE

PATIENT NAME _____

DIAGNOSIS _____

_____

SECONDARY DIAGNOSIS / PRECAUTIONS _____

X-RAY/MRI/CT SCAN, ETC. RESULTS _____

EVALUATE AND TREAT

MANUAL THERAPY
❑ TRACTION
❑ JOINT MOBILIZATION
❑ MYOFACIAL RELEASE
❑ STRETCHING
❑ _____

THERAPEUTIC EXERCISE
❑ PASSIVE
❑ ACTIVE ASSISTED / ACTIVE
❑ PROPRIOCEPTIVE TRAINING
❑ RUSSIAN STIMULATION
❑ _____

❑ CORE STABILIZATION
❑ THERABAND EXERCISE
❑ RESISTED / PRE'S
❑ _____
❑ _____

MODALITIES
❑ MOIST HEAT / ICE
❑ ULTRASOUND
❑ IONTOPHORESIS
❑ ELECTRICAL STIMULATION
❑ _____

MANIPULATION
❑ CERVICAL
❑ THORACIC
❑ EXTREMITY
❑ LUMBAR / SACRUM / ILIUM
❑ _____

HOME PROGRAM
❑ _____
❑ _____
❑ _____
❑ _____
❑ _____

COMMENTS:

_____

_____

DURATION: 2 WKS 4 WKS 6 WKS 8 WKS

I certify that this patient is under my care and requires:
❑ Chiropractic ❑ Therapeutic Exercise

Clinician Signature: _____ Date: _____