BACK & BODY CHIROPRACTIC

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THERAPY ORDERS

❑ CHIROPRACTIC ❑ THERAPEUTIC EXERCISE ❑ SPINAL DECOMPRESSION

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
- ❑ ELECTRICAL STIMULATION
- ❑ ULTRASOUND
- ❑ MOIST HEAT / ICE
- ❑ KINESIOTAPE
- ❑ _____

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

HOME PROGRAM
- ❑ INCREASE ROM
- ❑ STRENGTHEN
- ❑ TENS UNIT
- ❑ _____
- ❑ _____

COMMENTS:

_____

_____

DURATION: 2 WKS 4 WKS 6 WKS 8 WKS

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

_____ Date: _____

Thank you for your referral