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|---|----------------------------|--|
| □ Chiropractic | \square Physical Therapy | \Box Chiropractic and PT |
| Patient Name: | | DOB: |
| Referred By: | | |
| | | |
| Precautions / Contraind | | |
| | □ Evaluate and Trea | at |
| Modalities At providers discretion AlterG Electrical Stimulation GameReady Low Level Laser Therap Mechanical Traction NormaTec Orthotics Spinal Decompression Taping ThermoStim Ultrasound | y (Cold Laser) | Therapeutic Exercise At providers discretion Body Mechanics Gait Training Home Exercises Manual Therapy / IASTM Massage Neuromuscular Re-education Postural Instruction Range of Motion Strengthening Stretching Vertigo |
| Manipulation | der my care and the ab | Comments ove treatment is medically necessary |
| Physician's Signature: | | Date: |