

POW PHYSICAL THERAPY

Pilates, Orthopedics, Women's Health

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PHYSICAL THERAPY PRESCRIPTION

Date _____ / _____ / _____

Patient Name _____

Dx _____

Precautions _____

Duration _____ x/week for _____ weeks

Signature _____

- Evaluate and Treat
- Manual Therapy
- Therapeutic Exercise
- Balance Training
- Modalities
- Other