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
- ☐ Pilates / Core Stabilization
- ☐ Electromyography/ Nerve Conduction Velocity Testing
- ☐ Other_____