# Johnson & Hayes
Physical Therapists®


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☐ **Huntsville - Providence**
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Patient: _____ Patient Phone: _____

Diagnosis: _____ Date of Surgery / Injury: _____

Precautions/Contraindications: _____

Insurance: _____

Policy/Group: _____ Date of Birth: _____

## ☐ Evaluate and Treat

- ☐ Joint Mobilization
- ☐ Soft Tissue Mobilization
- ☐ Strengthening
- ☐ Active/Passive Range of Motion
- ☐ Flexibility
- ☐ Bracing
- ☐ Custom Orthotics
- ☐ LSVT-BIG
- ☐ Vestibular - Dizziness + Balance
- ☐ Craniofacial Issues / TMJ
- ☐ Pelvic Health
- ☐ Breast Cancer Recovery/ Lymphedema

## Modalities as Indicated

- ☐ Ultrasound
- ☐ Electrical Stimulation
- ☐ Traction
- ☐ Iontophoresis/Phonophoresis
- ☐ Moist Heat/ Cryotherapy
- ☐ Paraffin
- ☐ Dry Needling
- ☐ Other:

I acknowledge that this treatment is medically necessary. Frequency: ____ /wk Duration: ____ wks

Physician Signature _____ Date: _____

Printed Physician Name _____