



JOHNSON & HAYES

PHYSICAL THERAPISTS

Huntsville Location
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Madison Location
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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
- Craniofacial Issues / TMD

Modalities as Indicated

- Ultrasound
- Electrical Stimulation
- Traction
- Iontophoresis/Phonophoresis
- Moist Heat/Cryotherapy
- Paraffin
- Other: _____

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

Physician Signature _____ Date _____

