HIGH LINE REHAB
PHYSICAL THERAPY

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High Line Rehab PT PC
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Patient_____ Date_____

Diagnosis_____

Precautions_____

☐ **PHYSICAL THERAPY EVALUATION**

PROCEDURES	**MODALITIES**
☐ Therapeutic Exercise	☐ Hot / Cold Packs
☐ Therapeutic Activities	☐ Electrical Stimulation
☐ Gait Training	☐ Ultrasound / Phonophoresis
☐ Manual Therapy • Soft Tissue Mobilization • Joint Mobilization	☐ Paraffin Bath
☐ Mechanical Cervical Traction	☐ Iontophoresis • w/ 4mg/mL dexamethasone ☐ Low Level Laser Therapy

Special Instructions_____

All of our patients receive individualized home programs & education

Frequency & Duration _____ times/week for _____ weeks

I certify the need for these services furnished under this treatment plan while under my care.

Physciain's Name: _____ NPI: _____

Physician's Signature _____