



Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ DOB: \_\_\_\_\_

**CENTRALIZED SCHEDULING LINE & FAX**  
 phone 520-884-9819 fax 520-884-0175

**EVALUATE & TREAT:** Please Indicate Frequency: Daily 3x 2x for \_\_\_\_\_ weeks

**FOLLOW POST-OP PROTOCOL:**

**TREATMENT GOALS:**

Decrease Pain  Increase ROM  Increase Strength & Function

**PROGRAMS:**

Shoulder  Core Stability  Low Back  Running  
 Work Conditioning  Balance  Vestibular  Strength

**EXERCISE**

Stabilization  
 McKenzie Method  
 Home Program  
 ROM Active  
 ROM Passive  
 Postural Training

**MANUAL THERAPY**

Myofascial Release  
 Joint Mobilization  
 Trigger Point Massage  
 **Dry Needling\***  
*\*(Must be checked for permission of treatment)*

**MODALITIES**

Hot Packs  
 Ultrasound  
 Ice  
 Electrical Stimulation  
 Traction  
 Iontophoresis\* Using:  
 Dexamethasone  
 Ketoprofen

**GAIT TRAINING**

Full Weight Bearing  
 PWB \_\_\_\_\_ %  
 Non Weight Bearing  
 Gait Analysis  
 Fall Risk Assessment

**PRECAUTIONS:** \_\_\_\_\_

*I authorize this treatment, which is medically necessary for the above named patient*

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

**WEST TUCSON**  
 1777 W. St. Mary's Rd  
 Tucson, AZ 85745

**EAST CENTRAL TUCSON**  
 6206 E. Pima, Suite 3  
 Tucson, AZ 85712

**NORTH FOOTHILLS**  
 1605 E. River Rd, Suite 201  
 Tucson, AZ, 85718

**NORTHEAST TUCSON**  
 8987 E. Tanque Verde, Suite 301  
 Tucson, AZ, 85749

All services are available without distinction to all program participants regardless of race, color, national origin, handicap, age or sexual orientation.

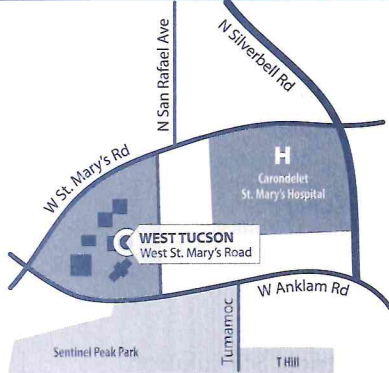


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[www.agilitypt.com](http://www.agilitypt.com)

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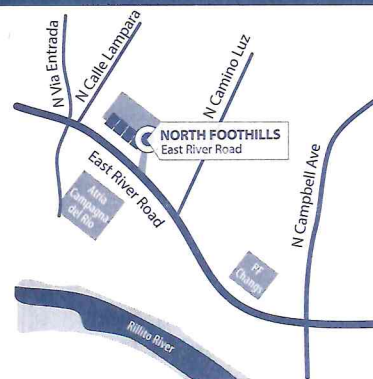
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