

PHYSICAL THERAPY PRESCRIPTION

Name: _____ Date of Birth : _____

Diagnosis / ICD 10 Code: _____

Comments / Precautions: _____

☐ **Evaluate & Treat As Appropriate**

Services:

- | | | |
|--|---|---|
| ☐ Strength / ROM / Stretching | ☐ Patient Education | ☐ Functional Training |
| ☐ Pain Relief Modalities | ☐ Vestibular Therapy | ☐ Manual Therapy |
| ☐ Neck Stabilization Program | ☐ Balance Training | ☐ Post Operative Services |
| ☐ Back Stabilization Program | ☐ Gait Training | ☐ Fall Prevention & Balance Training |
| ☐ Special Instructions: | | |

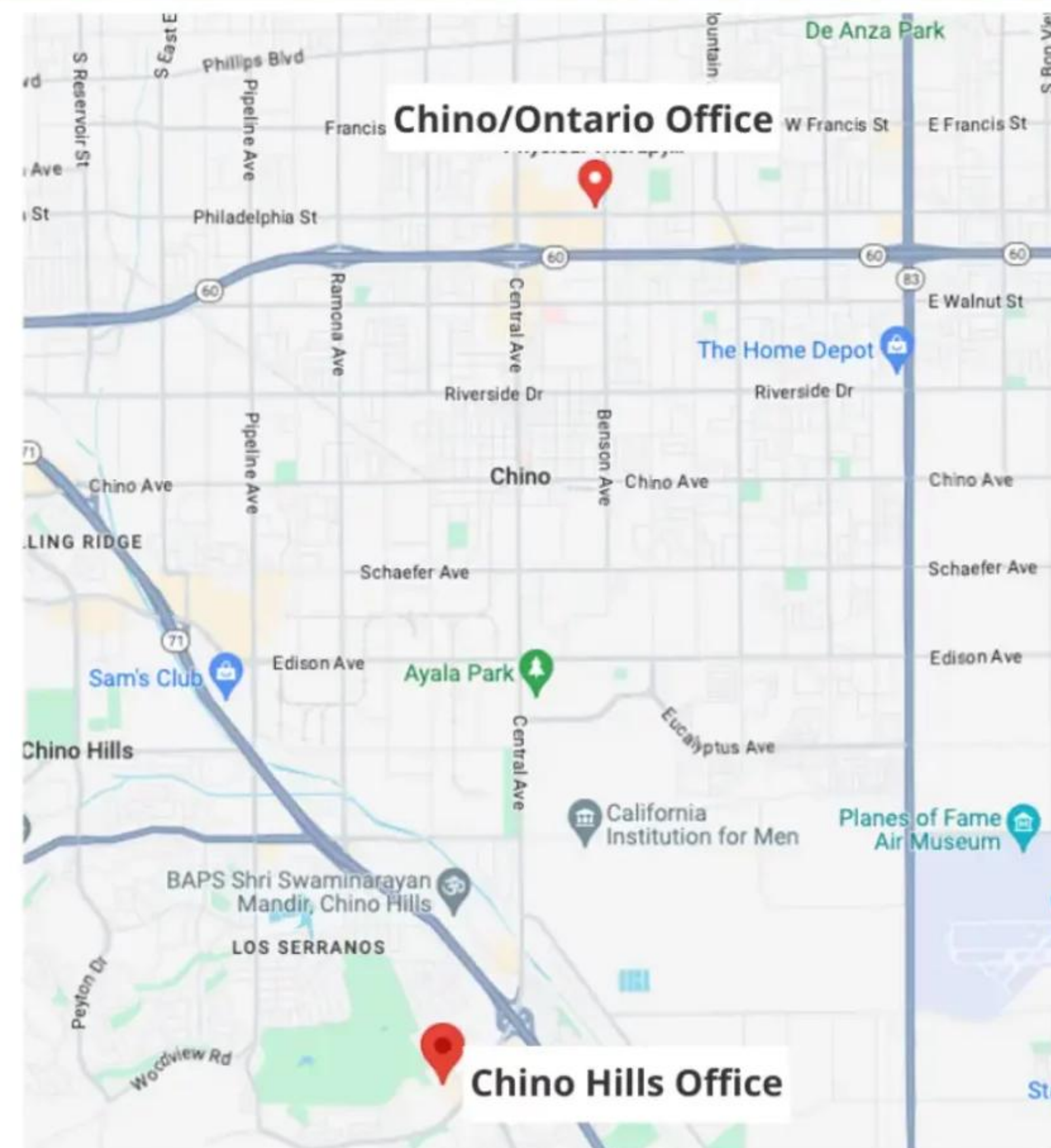
Treatment Frequency:

1 2 3 4 5 days per week for _____ weeks

**I Certify That The Prescribed Rehabilitation Is Medically Necessary*

Physician Signature: _____

Date: _____



EMPOWER PHYSICAL THERAPY AND WELLNESS

Chino Hills Office:

15944 Los Serranos Country Club Dr. #250 Chino Hills, CA 91709

P: (909) 907-0805 | F: (909) 907-0735

E: info@empowerPTwellness.com

Chino/Ontario Office:

5632 Philadelphia St. #102 Chino, CA 91710

P: (909) 925-0015 | F: (909) 925-0016

E: infochino@empowerPTwellness.com

**Early Morning and Evening Hours | Free Parking
Accepting All Major Insurances**

**Visit Us Online For More Information At:
www.empowerPTwellness.com**

