

KIRKLAND
PHYSICAL THERAPY



NOVELTY HILL
PHYSICAL THERAPY

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Novelty Hill Physical Therapy
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Patient _____ **Date** _____

Diagnosis _____

Procedures and Modalities

- | | |
|---|---|
| <input type="checkbox"/> Evaluate - and treat per PT | <input type="checkbox"/> ASTYM |
| <input type="checkbox"/> Heat (includes MH, US) | <input type="checkbox"/> Vestibular/Balance |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Traction |
| <input type="checkbox"/> Manual Therapy | <input type="checkbox"/> Exercise/Stretch/ROM |
| <input type="checkbox"/> MFR/Soft Tissue | <input type="checkbox"/> Diabetic Neuropathy |
| <input type="checkbox"/> Mobilization | <input type="checkbox"/> Patient Education |
| <input type="checkbox"/> Electrical/T.N.S./
Photon Light Therapy | <input type="checkbox"/> Back School |
| | <input type="checkbox"/> Other _____ |

Frequency/Week _____

Comments : _____

Signed _____

~ Thank you for your referral ~