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Physical Therapy • Aquatic Therapy

Patient Name: _____ Date: _____

Contact Phone: _____

Diagnosis/code: _____

Precautions / Restrictions: _____

Frequency: _____ Duration: _____

Prescription Form for PHYSICAL THERAPY

- Land Physical Therapy
- Aquatic Physical Therapy
- Evaluate and Treat
- Modalities
- Therapeutic Exercise
- Neuromuscular Re-Education
- AROM
- Modalities
- PROM
- Traction
- Strengthening
- Manual Therapy
- Stretching

SPECIALITY PROGRAMS

- Balance / Fall Prevention
- Work Injury / Return to Work
- Pediatrics
- Post-Operative Management
- Pelvic Floor
- Aerobic Conditioning
- Low Back Program
- Sports Specific Training

Special Instructions:

I certify that the above named patient is under my care and requires physical therapy services on an outpatient basis and under a plan established and reviewed within 30 days by me as attending physician.

Physician Signature _____