FYZICAL®
Therapy & Balance Centers

FYZICAL | _____
_____
_____
Phone: _____
Fax: _____

Special Instructions:

Patient Name: _____ Phone: _____

Referring Physician: _____ Date: _____

Diagnosis: _____

☐ Evaluate & Treat ☐ Continue Current Rx

Pre/Post-Op Rehabilitation

- ☐ Knee
- ☐ Hip
- ☐ Back
- ☐ Shoulder
- ☐ Neck
- ☐ Elbow
- ☐ Wrist/Hand
- ☐ Ankle/Foot

Balance Rehabilitation

- ☐ Balance Retraining Therapy
- ☐ Canalith Repos. Maneuver
- ☐ Neurological Gait Training
- ☐ NIR Infrared Treatment

Orthopedic Rehabilitation

- ☐ Strengthening
- ☐ Flexibility/R.O.M.
- ☐ Stabilization
- ☐ Soft Tissue Mobilization
- ☐ Joint Mobilization
- ☐ Other: _____

Programs

- ☐ Balance Retraining
- ☐ Vestibular Therapy
- ☐ Headaches
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ S/P CVA
- ☐ Parkinsons
- ☐ Sports Specific
- ☐ Work Specific

Modalities

- ☐ Ultrasound
- ☐ Electrical Stimulation
- ☐ Iontophoresis
- ☐ Traction
- ☐ Other: _____

Patient Education

- ☐ Home Exercise Program
- ☐ Fall Prevention
- ☐ ADL Training
- ☐ Other: _____

Frequency: _____ Days per week

Duration: _____ Weeks / Months
circle one

Physician Signature: _____

Physician Name (Printed): _____