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www.evolutionphysicaltherapy.com

• Orthopedic and
Sports Rehabilitation



Patient Name: _____ Date: _____

Diagnosis: _____ Date of Surgery: _____
(please send operative report)

Frequency of treatment: _____ x per week for _____ weeks

Physical Therapy Prescription

Evaluate and treat

Therapeutic Exercise

- Flexibility
- Strength
- Endurance
- Agility / Coordination
- Sport-specific Training _____
- Body Mechanics / Postural Correction

Procedures

- Joint Mobilization
- Soft Tissue Mobilization
- Manual Traction
- P.N.F.
- Gait Training

Modalities

- Ultrasound
- Electrical Stimulation
- Iontophoresis
- EMG / Biofeedback
- Light Therapy (Cold Laser/Infrared)
- Ice
- Heat

Physician's Signature: _____ Date: _____

Comments:

**The next generation of
rehabilitation and
performance training**

*Body weight-assisted
treadmill*

- ACL Rehab
- Knee pain/PFS
- s/p menisectomy
- TKA
- s/p hip surgery
- Low back pain
- s/p L/S surgery
- Foot/ankle pain
- s/p foot surgery
- Plantar fasciitis
- Shin splints
- Performance training
- Other: _____

