Icon

Description automatically generated

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PATIENTS NAME:

DATE OF BIRTH:

DATE OF ONSET:

DIAGNOSIS / ICD-10:

 EVALUATE & TREAT

#  PHYSICAL THERAPY  MASSAGE THERAPY\*

 AQUATIC THERAPY

FREQUENCY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DURATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# \*FREQUENCY, DURATION AND DIAGNOSIS ARE REQUIRED FOR MASSAGE THERAPY

PRECAUTIONS / REMARKS:

Physical Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT

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## SIGNATURE DATE