HART
SPINE & REHAB
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☐ CHIROPRACTIC ☐ PHYSICAL THERAPY

FREQUENCY OF VISITS: _____ TIMES PER WEEK FOR _____ WEEKS

PATIENT NAME: _____ DOB: _____

PHONE NUMBER: _____

DIAGNOSIS: _____

SECONDARY DIAGNOSIS / PRECAUTIONS: _____

XRAY/MRI/CT SCAN ETC RESULTS: _____

☐ EVALUATE AND TREAT AS APPROPRIATE

- ☐ TRACTION THERAPY (CERVICAL/LUMBAR)
- ☐ ELECTRICAL STIMULATION
- ☐ THERAPEUTIC EXERCISES
- ☐ STRENGTH / ROM / STRETCHING
- ☐ PATIENT EDUCATION
- ☐ BALANCE / GAIT TRAINING
- ☐ MANUAL THERAPY / JOINT MOBILITY
- ☐ HOME TENS UNIT / TRAINING
- ☐ SELF CARE / HOME MANAGEMENT
- ☐ OTHER: _____

SPECIAL INSTRUCTIONS / ADDITIONAL COMMENTS:

_____

_____

_____ _____
PHYSICIAN'S SIGNATURE DATE

_____
PHYSICIAN'S PRINTED NAME

CALL NOW!
334.558.0906