



yoshimoto physical therapy

Patient: _____ Phone: _____ Date: _____

Diagnosis: _____ Date of Injury: _____

ICD-10 Code(s): _____

Referring Physician: _____

Insurance Company: _____ Adjustor or Claim Number: _____

Rx: _____ TIMES A WEEK FOR _____ WEEKS.

- | | | |
|--|---|---|
| <input type="radio"/> Evaluate & Treat | <u>Modalities:</u> | <input type="radio"/> Education |
| <input type="radio"/> ROM/Stretches | <input type="radio"/> Low Level Cold Laser | Prevention & Mechanics, Pain Management |
| <input type="radio"/> Therapeutic Exercises | <input type="radio"/> Ultrasound | <input type="radio"/> Home Exercise Program |
| <input type="radio"/> Therapeutic Activities | <input type="radio"/> Elec. Stimulation | <input type="radio"/> Special Instructions: |
| <input type="radio"/> Stabilization | <input type="radio"/> US / Elec. Stim. Combo | _____ |
| <input type="radio"/> Gait Training | <input type="radio"/> Iontophoresis | _____ |
| <input type="radio"/> ADL/Functional Training | <input type="radio"/> Heat/Cold | _____ |
| <input type="radio"/> Neuromuscular Re-Education | <input type="radio"/> Microcurrent | _____ |
| <input type="radio"/> Balance & Proprioception | <input type="radio"/> Functional Elec. Stim. | _____ |
| <input type="radio"/> Work Conditioning | <input type="radio"/> Massage/Manual Therapy | |
| | Joint Mobilization, Soft Tissue Mobilization/MFR, Manual Traction | |

Physician Signature: _____ Date: _____

Yoshimoto Physical Therapy
 600 Kapi'olani Blvd.
 Suite 409
 Honolulu, HI 96813
 Phone: (808) 525-5300
 Fax: (808) 525-5301
www.yoshimotophysicaltherapy.com

