

**Active Life Physical Therapy**  
 2600 Eldorado Parkway, Suite 130  
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**Patient Information:**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Phone: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Physical Therapy

- Evaluate & Treat
- Continue Therapy

General Orthopedics

- Pre-Operative
- Post-Operative
  - o Shoulder
  - o Elbow
  - o Wrist
  - o Spine
- o Hip
- o Knee
- o Ankle
- o Others \_\_\_\_\_

Manual Therapy

- Joint Mobilization
- Dry Needle
- Soft Tissue Mobilization/Graston Technique/Massage
- Muscle Energy Technique
- Myofascial Release
- Muscle Re-education / NMS

Neurological Rehabilitation

- LSVT Big Program
- Parkinson Disease
- Brain Injury Specialist
- TIA or Stroke
- Other \_\_\_\_\_

Functional Limitation(s)

- Balance /instability
- Decreased Function
- Difficulty walking
- Abnormal Movement
- Abnormal Posture
- Gait Abnormality
- Muscular Weakness
- Muscular Incoordination
- Equilibrium Disturbance
- Peripheral Neuropathy
- Vertigo / BPPV

Phase III /IV Cardiac Rehabilitation

- MI
- Bypass
- Other \_\_\_\_\_

Wellness Program and Group Exercise

- Flexibility
- Fall prevention / Balance
- Functional and Core endurance training
- ADL training

Notes: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Frequency (per week):   1   2   3   4   5  
 Duration:    weeks

Signature: \_\_\_\_\_

I certify that I have thoroughly examined this patient and determined that physical therapy is medically necessary.

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