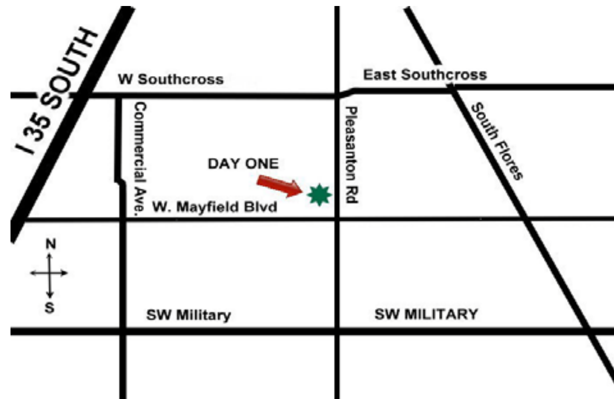
DAY ONE
PHYSICAL THERAPY & WELLNESS

1939 Pleasanton
SAN ANTONIO, TX 78211
(Located at the intersection of Pleasanton and W. Mayfield Blvd.)
Tel. (210) 922-8300 Fax: (210) 922-8304



PATIENT NAME ________________________________ DATE: ______________
Diagnosis: ____________________________ Diagnosis Code (s): ____________
Surgery ______________________________ Precautions: _________________

FREQUENCY: 1 2 3 4 5 6 visits/week

DURATION: 1 2 3 4 5 6 7 8 weeks

☐ *Evaluate & treat as indicated:* ___________________________________

Therapeutic Exercise/ Activities	Manual Therapy	Modalities
☐ As indicated per P.T.	☐ As indicated per P.T.	☐ As indicated per P.T.
☐ PROM/AAROM/AROM	☐ Joint Mobilization	☐ Hot/Cold Pack
☐ Strengthening	☐ Soft Tissue Mobilization	☐ Ultrasound
☐ Stretching	☐ Myofascial Release	☐ E-Stim
☐ Neuromuscular Re-ed	☐ Other _____________	☐ NMES
☐ Proprioceptive Training		☐ Traction
☐ Gait Training		☐ Other
☐ Other:______________		

____ ____________________

Physician Signature *Date*

I certify that the prescribed treatment is an appropriate course of and the services prescribed are medically necessary.

Revised 3 11 2010