

# *Atlantis Physical Therapy Group, Inc.*

*Personalized Fitness Solutions to Enhance People's Lives*

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## **Physical Therapy Prescription Form**

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Telephone: \_\_\_\_\_

Insurance: \_\_\_\_\_ Card No: \_\_\_\_\_

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

Frequency: \_\_\_\_\_/Week \_\_\_\_\_ Duration: \_\_\_\_\_/Week \_\_\_\_\_

Special instructions: \_\_\_\_\_

Name of Doctor: \_\_\_\_\_ Upin/Provider #: \_\_\_\_\_

Address: \_\_\_\_\_

Evaluate and Treat

Pain Management Program

Physical Therapist to evaluate and give the treatment below

Physical Therapy on hold due to: \_\_\_\_\_

_____	Hot Packs	_____	PRE Strengthening Exercises
_____	Cold Packs	_____	Isometric Exercises
_____	Paraffin Bath	_____	Muscles Stretching
_____	Whirlpool	_____	Williams (Low Back) Exercises
_____	Cervical Traction	_____	McKenzie Exercise (Extension)
_____	Pelvic Traction	_____	Coordination Exercises
_____	Electrical Muscle Stimulation	_____	Breathing Exercises
_____	Massage (therapeutic)	_____	Muscles Re-education
_____	Transcutaneous Electrical	_____	Proprioceptive Neuromuscular
_____	Nerve Stimulation (TENS)	_____	Facilitation Technique
_____	Joint Mobilization	_____	Postural Drainage
_____	(Manipulation)	_____	Gait Training
_____	Iontoporesis	_____	Non-weight bearing _____ leg
_____	Biofeedback	_____	Partial-weight bearing _____ leg
_____	Passive Range-of-Motion	_____	Parallel Bars, Wall, Crutches,
_____	Active Range-of-Motion	_____	Cane
_____	Ultrasound	_____	Proper Body Mechanics

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date