Origin.

Physical Therapy Prescription
All fields required

Patient Name

Patient DOB

Patient Email

Patient Phone

Prescribing Provider Name (Please print)

Provider Type (Select one)

☐ M.D. ☐ D.O. ☐ D.D.S.

☐ P.A. ☐ C.N.M.

Treatment Frequency & Duration (Select one)

No substitutions

☐ PRN / PT discretion ☐ ___ x per week for ___ weeks

Diagnosis (Select all that apply)

Pelvic Floor:

- ☐ Pelvic pain
- ☐ Stress incontinence
- ☐ Urge incontinence
- ☐ Urinary urgency
- ☐ Fecal incontinence
- ☐ Fecal urgency
- ☐ Prolapse
- ☐ Constipation
- ☐ Dyspareunia
- ☐ Vaginismus
- ☐ Vulvodynia

Ortho/General:

- ☐ Low back pain
- ☐ Sciatica
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Hip pain
- ☐ Shoulder pain
- ☐ Wrist pain
- ☐ Knee pain
- ☐ Lower abdominal pain
- ☐ Foot/ankle pain
- ☐ Muscle spasm

- ☐ Muscle weakness
- ☐ Scar condition
- ☐ Difficulty walking
- ☐ Abnormal posture
- ☐ Other pregnancy related condition
- ☐ Other:

Comments/Precautions (Optional)

Signature of Prescribing Provider
(Provider signature required—no stamps, please!)

Today's Date

Prescription invalid if all fields are not complete.

Origin.

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About us:

- Georgia licensed physical therapists
- In-network coverage with major insurance providers
- In-office and virtual care options
- Experts in prenatal, postpartum, and pelvic health

Book your first visit at
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