

Origin.

Physical Therapy Prescription

All fields required

Patient Name

Patient Email

Prescribing Provider Name (Please print)

Patient DOB

Patient Phone

Provider Type (Select one)

M.D. D.D.S. D.M.D.
 D.O. D.C. P.A. D.P.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:



Tennessee licensed physical therapists



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