Origin.

Physical Therapy Prescription

All fields required

Patient Name

Patient DOB

Patient Email

Patient Number

Prescribing Provider Name (Please print)

Provider Type (Select one)

☐ M.D. ☐ D.O. ☐ D.P.M. ☐ D.D.S.

☐ CNM/NP/APRN/ACNS ☐ D.C. ☐ P.A.

Treatment Frequency & Duration (Select one)

☐ 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

(M.D., D.O., D.D.S., D.C., NP, APRN, ACNS, P.A., D.P.M. signature required —no stamps, please!)

Today's Date

Prescription invalid if all fields are not complete.

Origin.

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About us:

- Texas licensed physical therapists
- Low cash rates, superbill support for OON billing
- In-office and virtual care options
- Experts in prenatal, postpartum, and pelvic health
- Participating in-network provider with most insurance

Book your first visit at
hello.theoriginway.com