Body Mechanix[SM]

Physical Therapy

of Escanaba, LLC

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Patient: ______________________________ Date: ____________________

Diagnosis: ____

❑ **Evaluate and Treat**

- ❑ Therapeutic Exercise
- ❑ Strengthening
- ❑ Stretching
- ❑ Active Range of Motion
- ❑ Passive Range of Motion
- ❑ Endurance Exercise
- ❑ Postural Exercise
- ❑ ADL Training
- ❑ Gait Training
- ❑ Balance Training
- ❑ Body Mechanix Training
- ❑ Neuro Developmental Training
- ❑ Stroke Rehab
- ❑ Spinal Rehab
- ❑ Transfer Skills
- ❑ Manual Therapy
- ❑ Electrical Stimulation
- ❑ Ice
- ❑ Ultrasound
- ❑ Neuromuscular Re-education
- ❑ TENS Treatment
- ❑ Moist Heat
- ❑ Iontophoresis
- ❑ Parrafin
- ❑ Contrast Bath
- ❑ Traction
- ❑ Joint Protection Instruction
- ❑ Fine Motor Coordination
- ❑ Home Exercise Program
- ❑ Custom Orthotics

❑ Other – Please Specify ____

Frequency: __________x / wk for_________weeks

I certify that this patient is under my care and is in need of skilled Physical Therapy Services that are medically necessary.

Physician Signature: ____