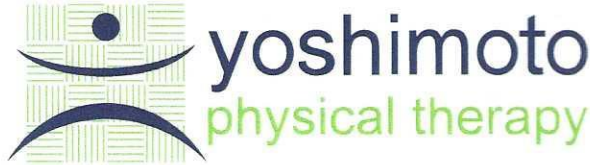


E 'Imi I Ke Ola - Seek Health



Patient: _____ Phone: _____ Date: _____

Diagnosis: _____ Date of Injury: _____

ICD-10 Code(s): _____

Referring Physician: _____

Insurance Company: _____ Adjuster or Claim Number: _____

Rx: _____ TIMES A WEEK FOR _____ WEEKS.

Evaluate & Treat

Modalities:

ROM/Stretches

Low Level Cold Laser

Mechanical Traction

Therapeutic Exercises

Ultrasound

Education
Prevention & Mechanics, Pain Management

Therapeutic Activities

Elec. Stimulation

Home Exercise Program

Stabilization

US/Elec. Stim. Combo

Special Instructions:

Gait Training

Iontophoresis

ADL/Functional Training

Heat/Cold

Neuromuscular Re-Education

Microcurrent

Balance & Proprioception

Functional Elec. Stim.

Work Conditioning

Manual Therapy:
Joint Mobilization, Soft Tissue Mobilization (STM), Manual Traction,
Instrument Assisted STM, Myofascial Release

Physician Signature: _____ Date: _____

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