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Sports Medicine
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Physical Therapy Prescription

Patient Name:____Date:_________________

Diagnosis:____

Evaluate & Treat – please provide with home exercise program

ROM
- PROM / AAROM / AROM
- Restrictions: ____

Strengthening
- Theraband Exercises
- Core Strengthening
- Closed Chain Quad Strengthening
- No isokinetic exercises
- Restrictions:____

Modalities
- Per therapist's discretion
- Ultrasound
- Iontophoresis
- Electrical Stimulation

Work Conditioning

Functional Capacity Exam

Other:____

Frequency: _________x/week/month for _________weeks/months

Signature:_______________________________________

Please fax all reports to 312-942-1517 at least 3 days prior to patient's next appointment.