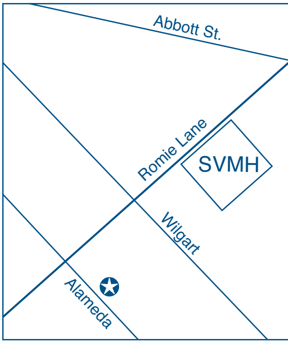

MYERS®
Physical Therapy

515 Alameda Ave., Ste. B., Salinas, CA 93901
Phone: 831.757.1900 Fax: 831.757.1010
Jason Myers, PT, MS, OCS

Patient: ____________________

Diagnosis: ____________________

Special Instructions: ____________________

❑ P.T. Evaluation & Treatment

- ❑ Hot Packs
- ❑ Ice
- ❑ Whirlpool
- ❑ Paraffin
- ❑ Ultrasound
- ❑ Phonophoresis
- ❑ Iontophoresis
- ❑ Traction
  - ___Cervical
  - ___Pelvic
  - ___Manual
- ❑ Electic Stimulation
- ❑ TENS
- ❑ Joint Mobilization
- ❑ Soft Tissue Mobilization
- ❑ Muscle Re-education
- ❑ Massage
- ❑ Exercise
  - ___Passive ROM
  - ___Active ROM
  - ___Resistive/PRE
- ❑ Back Program
- ❑ Cervical Program
- ❑ Gait Training
- ❑ Home Program
- ❑ Joint Taping

Frequency:____/Week **Duration:_____Weeks**

I certify___re-certify___that I have examined the patient, that physical therapy is medically necessary and that service wil be furnished while the patient is under my care, and the plan is established and will be reviewed every 30 days, or more often if the patient's condition requires. I estimate that these services will be needed for about___(days) (weeks) (months).

Signature: ____________________ Date: ____________________