HEALTH ACTIONS PHYSICAL THERAPY

FITNESS • HEALTH • WELLNESS

PHYSICAL THERAPY PRESCRIPTION

Patient's Name:

____

DOB: ______/_______/_______ **Phone #:** _______________________________

Diagnosis/Chief Complaint:

____

____

☐ **Evaluate & Treat** Onset Date: _________ Surgery Date: _________

Precautions/Comments/Special Instructions:

____

____

Frequency: __________ Duration: ____________

I certify that physical therapy services are required and authorized by me.

_______________________________ _______________

Physician's Signature **Date**

1711 College Ave Jackson, AL P: 251.246.5761 F: 251.246.3779

295 S. Jackson St Grove Hill, AL P: 251.275.4905 F: 251.275.7906

451 Safford Ave Thomasville, AL P: 334.636.1461 F: 334.636.1463

2071 S. Al. Ave Monroeville, AL P: 251.575.1933 F: 251.575.2807

100 Emma Dr Troy, AL P: 334.670.5435 F: 334.670.5234

4300 W. Main St, Ste 14 Dothan, AL P: 334.758.8288 F: 334.758.6988

www.healthactionspa.com