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Medical Prescription Form

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

A. Diagnosis (Include ICD-10 codes that specifically address Manual Therapy Treatment)

\_\_\_\_\_  
\_\_\_\_\_

Condition is related to:  Injury  Illness  
 Other: \_\_\_\_\_

B. Referring Health Care Provider (HCP)

HCP Name: \_\_\_\_\_

Provider #: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

Email: \_\_\_\_\_

Reporting:  After initial visit  At end of prescription

Send by :  Mail  Email

C. Medically Necessary Treatment:

Application (Direct and Indirect)

- All of the Below
- Head \_\_\_\_\_
- Neck \_\_\_\_\_
- Chest \_\_\_\_\_
- Shoulders \_\_\_\_\_
- Abdomen \_\_\_\_\_
- Back \_\_\_\_\_
- Low back/Hips \_\_\_\_\_
- Upper extremities \_\_\_\_\_
- Lower extremities \_\_\_\_\_
- Other \_\_\_\_\_

D. Treatment Goals

- Decrease pain
- Decrease muscle tension/spasm
- Decrease compensatory patterns
- Increase mobility
- Increase strength
- Restore function
- Restore posture
- Maintain associated structures
- All of the Above
- Other \_\_\_\_\_

Specific Instructions:

\_\_\_\_\_  
\_\_\_\_\_

Duration:  60 minute sessions  90 minute sessions

- 1x wk for \_\_\_\_\_ wks
- 2x wk for \_\_\_\_\_ wks
- 3x wk for \_\_\_\_\_ wks
- 2x month for \_\_\_\_\_ months
- 1x month for \_\_\_\_\_ months

HCP Signature: \_\_\_\_\_ Date: \_\_\_\_\_