

Patient Name _____ Today's Date _____
 Patient Phone _____
 Diagnosis _____
 PRECAUTIONS _____
 Goals _____
 Frequency and Duration (or number of visits) _____

☐ **Evaluate and Treat**

Procedures

- ☐ Therapeutic Exercise
- ☐ Joint Mobilizations / High Velocity Techniques
- ☐ Neuromuscular Therapy / Soft Tissue Mobilization
- ☐ Manual Traction
- ☐ Range of Motion
- ☐ Gait Training
- ☐ Weight Bearing

Modalities

- ☐ Iontophoresis
- ☐ Electrical Stimulation
- ☐ Phonophoresis
- ☐ Ultrasound
- ☐ Hot Packs and Cold Packs

Treatment Programs

- ☐ Home Exercise Program / Stabilization Program
- ☐ Back School
- ☐ Posture Education

Acupuncture

- ☐ Dry-needling
- ☐ Pain Management
- ☐ Relaxation / Meditation Techniques

Chiropractic

- ☐ Joint Mobilization / High Velocity Techniques
- ☐ Soft Tissue Mobilization
- ☐ Alignment Assessment

Other Services

- ☐ Massage Therapy
- ☐ Personal Training
- ☐ Post concussion Physical Therapy
- ☐ Trigger Point Dry Needling
- ☐ Sports Physical Therapy
- ☐ Vestibular Rehabilitation / Balance Assessment & Therapy
- ☐ Ergonomic Analysis

Physician's Name _____	Phone _____
Signature _____	

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