REVIVAL PERFORMANCE PHYSICAL THERAPY

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San Antonio, TX 78216

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Phone: 210-750-9004 | Fax: 210-866-0201

Patient Name:_________________________ **DOB:**_________________

Patient Phone Number:_________________________

Injury/Dx/ICD-10:_________________________ **Surgery/Injury Date:**_____________

Comments/Precautions:____

- ☐ **Evaluate and Treat as Appropriate**

Treatments:

- ☐ Strength & Conditioning
- ☐ Pre/Post-Op Protocol
- ☐ ROM/Stretching
- ☐ Stabilization/Posture
- ☐ Soft Tissue/Cupping/Scraping
- ☐ Electrical Stimulation
- ☐ Sports Performance
- ☐ Patient Education
- ☐ Gait Training
- ☐ Balance/Coordination
- ☐ Joint Mobilization/Manipulation
- ☐ Kinesio Taping
- ☐ Trigger Point Dry Needling
- ☐ _________________________

Frequency x/week: 1 2 3 4 5 Duration: 1-4 4-8 8-12 weeks

Physician Signature (required):_________________________ **Date:** _____________

Physician Name (Print): _________________________ **NPI:**_____________

Thank you for your referral to the Revival Performance team!