

XPRESS **URGENT CARE**

PATIENT NAME: _____ PHONE: _____

DATE OF BIRTH: _____

DIAGNOSIS: _____

SECONDARY DIAGNOSIS / PRECAUTIONS: _____

• PHYSICAL THERAPY

• JOINT MOBILITY

• REHABILITATION SERVICES

PROGRAMS

KINETIC ACTIVITIES

MODALITIES

- Neck Rehab
- Back Rehab
- Shoulder Rehab
- Knee Rehab (Wt. Bearing
Non-Weight Bearing)
- Wrist/Hand Rehab
- Ankle Rehab
- PRP
- Other
- _____

- Strengthening/Stabilization
- Flexibility/Stretching
- Neuromuscular Re-Education
- Therapist Recommendation:

• CHIROPRACTIC TREATMENT

- Electric Muscle Stim
- Ultrasound/Phonophoresis
- Hot/Cold Packs
- Myofascial Release/Manual Traction
- Joint Mobilization
- Motorized Vehicle Accident
- Worker's Compensation
- Massage
- Other
- _____

COMMENTS:

DURATION: 2WEEKS 4WEEKS 6WEEKS 8WEEKS

I certify that this patient is under my care and requires the listed care above

Print Provider's Name: _____

Signature: _____ Date: _____

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