In Motion Therapy™

Patient Name _____ **DOB** _____

Patient Contact Number _____ **Injury Date** _____

Referring Physician (Print) _____

Diagnosis _____

Recommendations: Frequency-Duration

Please Check all that may apply:

_____ **Biofeedback**

_____ **Evaluate & Treat**

_____ **Exercise**

_____ **Myofascial Release**

_____ **Neufit Stimulation**

_____ **Pelvic Floor**

_____ **Cranio-Sacral**

_____ **E-Stim**

_____ **Joint Mobilization**

_____ **Muscle Energy Technique**

_____ **Neuromuscular Re-Ed**

_____ **Stabilization Exercise**

Referring Physician Signature _____

Date _____

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