



AZHAR THERAPY & FITNESS

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www.azhar.us

Name: _____

Diagnosis: _____

Type of Surgery/ Date: _____

Precautions/Limitations: _____

EVALUATE & TREAT _____

_____ Therapeutic Modalities

Moist Heat
Cold Pack
Ultrasound
Phonophoresis
Iontophoresis
Electrical Stimulation
TENS instructions
Cervical Traction

_____ Manual Therapy

Soft Tissue Mobilization
Trigger Point Therapy
Myofascial Release
Manual Traction
Manual Stretching
Joint Mobilization
ROM

_____ Women's Health

Pelvic Floor Strengthening
Back Pain Management
(pre/post-partum)

_____ Therapeutic Applications

Therapeutic Exercise
Kinetic Exercise
Proprioception & Balance
Gait Training
Progressive Resistive Exercise
Neuromuscular Exercise
Spinal Stabilization
Pilates (Core Strengthening)
Stretching

_____ Aquatic Therapy

SPECIAL INSTRUCTIONS:

Frequency: _____ Duration: _____

Physician's Signature: _____ Date: _____

Next Physician Appointment: _____

This prescription is medically necessary & expires 30 days from above date