

JACON C. CHUN  
MPT, ATC, CSCS

DIRECTOR OF PHYSICAL  
THERAPY



194 FRANCISCO LANE  
SUITE 104  
FREMONT, CA 94539  
P: 510-656-3777  
F: 510-656-3750

PATIENT'S NAME: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

**PHYSICAL THERAPY REQUESTS:**

- |  |  |
|--|--|
| <input type="checkbox"/> EVALUATE AND TREAT                      | <input type="checkbox"/> MODALITIES                  |
| <input type="checkbox"/> ORTHOTICS EVALUATION                    | ○ ULTRASOUND   |
| <input type="checkbox"/> MYOFASCIAL RELEASE                      | ○ ELECTRICAL STIMULATION                             |
| <input type="checkbox"/> JOINT MOBILIZATION                      | ○ IONTOPHORESIS                                      |
| <input type="checkbox"/> THERAPEUTIC EXERCISE                    | <input type="checkbox"/> TRACTION (CERVICAL/ LUMBAR) |
| <input type="checkbox"/> BODY MECHANICS/<br>ERGONOMICS EDUCATION | <input type="checkbox"/> OTHER                       |

FREQUENCY AND DURATION: \_\_\_\_\_ TIMES PER WEEK FOR \_\_\_\_\_ WEEKS

SPECIAL INSTRUCTIONS/ COMMENTS: \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(I CERTIFY THAT THE PRESCRIBED REHABILITATION IS MEDICALLY NECESSARY AND IS APPROVED).

***WHERE EVERYONE'S A PRO***