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Honolulu, HI 96814



## PATIENT INFORMATION

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Insurance: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

Special Instructions: \_\_\_\_\_  
\_\_\_\_\_

## TREATMENT

Evaluate and Treat

Movement Analysis

### Manual Therapy

Soft Tissue Mobilization

Joint Mobilization

ROM/Stretches

Myofascial Release

Manual Stretching

### Education

Home Exercise Program

Ergonomic Training

Back Mechanics

### Therapeutic Exercise

Postural Education

ROM/Stretches

Strengthening

Balance and Proprioceptive Training

Gait Training

ADL/Functional Training

Work Hardening

Pilates Based Core Stabilization

Home Exercise Program

Pre/Post Natal Considerations

### Modalities

Ultrasound

Electrical Stimulation

Taping

Heat/Ice

Iontophoresis

### Programs

Sport Specific Training

Pilates Based Stabilization

Balance and Fall Prevention

Parkinson Gait/Balance/Posture

Spine Wellness

Pre/Post Natal

\_\_\_\_\_  
Physician Signature Date

\_\_\_\_\_  
Printed Physician Name

Provider Stamp or Print Address  
Phone & Fax Number