

PHYSICAL THERAPY PRESCRIPTION

DIAGNOSIS: (LEFT/ RIGHT)

DATE _____

LUMBAR SPINE THERAPY PRESCRIPTION

___ Lumbar Stabalization program/ Core strengthening

___ Flexibility/ Strengthening/ Endurance – Teach daily home program

___ Postural Exercises

___ Lumbar, Hamstring, Gluteus, Hip stretching program

___ Modalities as needed (Ultrasound/ Phonophoresis/ E-stim)

Treatment: _____ **times per week** _____ **Home Program**

Duration: _____ **weeks**

**Please send progress notes.

**Physician's
Signature:** _____
Stephan J. Sweet, M.D., M.P.H.