



**MOVEMENT
STATE**
PHYSICAL THERAPY & SPORTS REHAB

4553 N Loop 1604 W Suite 1115
San Antonio, TX 78249
Phone/Fax/Text: (210) 756-5556
Email: admin@mvmstatept.com
Web: www.mvmstatept.com

Patient Name: _____ DOB: ___/___/___

Phone: (____) _____ - _____

Diagnosis: _____

ICD-10 Codes:

1) _____ 2) _____ 3) _____ 4) _____

Surgery/Injury Date: _____

Weight-Bearing Precautions: _____

Post-Operative Precautions: _____

THERAPY SERVICES REQUESTED

Evaluation and Treat as appropriate Post-Operative Care

TREATMENT

- Manual Therapy
- Therapeutic Exercise
- Cupping
- Dry-Needling
- Joint Manipulation
- Kinesiotaping
- Blood Flow Restriction Training

TESTING

- Return to Sport Testing
- Gait Analysis
- Running Analysis
- Functional Movement Screen
- Objective Strength Testing
w/digital dynamometer

Other: _____

Referring Physician (Print): _____

Referring Physician (Signature): _____

Date: _____

Phone: (____) _____ - _____

Fax: (____) _____ - _____