



# Galloway Therapy, PLLC

Physical Therapy and Aquatic Rehab

*"Results in Rehabilitation"*

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PHYSICAL THERAPY  
PRESCRIPTION

Name \_\_\_\_\_ Date \_\_\_\_\_

Diagnosis/Condition \_\_\_\_\_

Precautions \_\_\_\_\_ Date of Onset \_\_\_\_\_

## INSTRUCTIONS

- Evaluate and initiate appropriate therapy
- Aquatic Therapy
- Functional Capacity Evaluation/Assessment
- Fall Risk/Balance Assessment

Please administer the following treatment:

- |  |  |
|--|--|
| <input type="checkbox"/> Alter G Antigravity Treadmill       | <input type="checkbox"/> Ultrasound                            |
| <input type="checkbox"/> Cold Packs/Hot Packs                | <input type="checkbox"/> TENS Unit & Supplies                  |
| <input type="checkbox"/> Electrical Stimulation              | <input type="checkbox"/> Intermittent Traction                 |
| <input type="checkbox"/> Therapeutic Exercise                | <input type="checkbox"/> Backcare Exercises                    |
| <input type="checkbox"/> Vasopneumatic Compression           | <input type="checkbox"/> Iontophoresis                         |
| <input type="checkbox"/> Gait Training & Weight Precautions  | <input type="checkbox"/> Heel Lift, Splint, Brace (circle one) |
| <input type="checkbox"/> ROM, AROM, PROM, AAROM (circle one) |  |

Other: \_\_\_\_\_

## TREATMENT PLAN

- Therapist's Discretion
- Duration of treatment \_\_\_\_\_ days a week for \_\_\_\_\_ weeks (number)

ADDITIONAL COMMENTS: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

