



Thank you for
allowing us to be an
extension of your
care!

Patient Name: _____ Date: _____

Diagnosis/Chief Complaint: _____

____ Evaluate and Treat

- ____ Dry Needling (must be checked if indicated)
- ____ Manual Therapy
- ____ Range of Motion / Flexibility
- ____ Sports Injury / Rehabilitation
- ____ Post-Surgical Protocol
- ____ Aquatic Therapy
- ____ Strengthening
- ____ Pain Modalities
- ____ Balance / Stability
- ____ Gait
- ____ Other

Special Orders / Frequency & Duration: _____

Referring Physician Signature

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Leesburg, VA 20176
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Lansdowne Location:
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