Total Activation
THE NEW 5 STEP FITNESS MANTRA
www.totalactivation.com

Exercise Prescription
Physical Therapy Referral

Patient Name: ______________________________

Diagnosis: ______________________________

Conditions:

☐ Neck pain	☐ Abnormal Posture	☐ Diabetes
☐ Back Pain	☐ Abnormal Gait	☐ Hypoglycemia
☐ Shoulder Pain	☐ Lack of Coordination	☐ Hyperglycemia
☐ Hip Pain	☐ Edema	☐ Impaired Fasting Glucose
☐ Knee Pain	☐ Muscle Wasting	☐ Dysmetabolic Syndrome
☐ Osteroarthritis	☐ Fibromyalgia	☐ Hypertension
☐ Osteoporosis	☐ Chronic Fatigue	☐ Obesity
☐ Difficulty Walking	☐ Insulin Resistant	☐ Hyperlipidernia
		☐ Weight Gain

Procedures: { } PT Evaluate & Treat

{ } Other (please specify) ______________

Frequency: 1 2 3 4 5 times per week

Duration: 4 5 6 7 8 weeks

Comments/Precautions/Restrictions:

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PLEASE SEND COPIES OF TEST RESULTS
AND RECENT BLOOD WORK

____
Physician Signature

____
Date