GROVE
SPINE & SPORTS CARE
CENTER FOR SPORTS INJURIES, CHIROPRACTIC & REHAB

Patient Name: _____

Diagnosis: _____

Medical Precautions: _____

Date of Onset/Surgery:_____

_____ times/week for ____ weeks

❑ **EVALUATE AND TREAT**

TREATMENT PRESCRIPTION
- ❑ AAROM, AROM, PROM
- ❑ Strength Training
- ❑ Balance Training
- ❑ Home Exercise Program
- ❑ Soft Tissue Mobilization, Graston
- ❑ Active Release Technique
- ❑ Joint Mobilization
- ❑ Spinal Manipulation
- ❑ Posture, Body Mechanics
- ❑ Neuromuscular Re-Education
- ❑ Spinal Stabilization
- ❑ Ultrasound
- ❑ Dry Needling
- ❑ NKT
- ❑ Taping – Kinesio, Sports Performance

SPORTS PERFORMANCE ENHANCEMENT PROGRAMS
- ❑ Sports Biomechanical Analysis
- ❑ Sports Conditioning Program
- ❑ Pre, Post Race Runners Clinic
- ❑ Women's Sports Medicine Center

Notes:

I hereby certify these services as medically necessary for the patient's plan of care.

Physician's Signature: _____ **Date:** _____

Print Name: _____

8130 Boone Boulevard, Suite 110, Tysons Corner, VA 22182 | Office: 703.760.8110 | Fax: 703.760.8111
www.grovespinesports.com | front@grovespinesports.com