PHYSICAL THERAPY PRESCRIPTION

Jeffrey Wong, MD
SCOS Orthopedic Specialists
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DATE: _____

PATIENT NAME: _____

D.O.B: _____ **MRN: _____**

DIAGNOSIS: HAMSTRING STRAIN
❒ Right ❒ Left ❒ Bilateral

Ice / Massage / Anti-Inflammatory Modalities

Range of Motion – ❒ prone PROM ❒ AAROM ❒ AROM

Hamstring Strengthening – focus on eccentrics

Iliotibial Band, Abductor, Adductor Stretching / Strengthening

___ Other: _____

Treatment: ❒ Eval and Treat or ❒ 1 ❒ 2 ❒ 3 times per week

Duration: ❒ 4 ❒ 6 weeks

❒ Home Program

**Please send progress notes.

Physician's Signature**:** _____

NPI #: 1164790507