

# Therapy Plus

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## Physical Therapy Prescription

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

- Evaluate and Treat
- Continue Physical Therapy
- Specific

Recommendations: \_\_\_\_\_

Frequency: \_\_\_\_\_ Times per week.

Duration: \_\_\_\_\_ Weeks

Doctors Signature: \_\_\_\_\_

## Physical Therapy for:

Chronic Pain  
Back & Neck Injuries  
Orthopedic Injuries  
Poor Circulation  
Difficulty Walking  
Unstable Balance  
Fibromyalgia  
Diabetes Care

## Also Offering

Transportation Assistance  
Home Visits

