FIRST POST REHAB
Washington, DC
202-855-4710
info@integrativepostrehab.com

NAME: ______________________________ **DATE:** ____________

DIAGNOSES / RX: ______________________________

PROGRAM:

- ◇ POST REHAB
- ◇ MEDICAL EXERCISE
- ◇ PRENATAL
- ◇ POSTPARTUM
- ◇ STRENGTH TRAINING

FREQUENCY & DURATION:

_____ TIMES PER WEEK

FOR

_____ WEEKS

REFERRED BY: ______________________________

SIGNATURE: ______________________________