POWELL
METABOLIC PROGRAM

Phone: 480-378-3522
Fax : 480-378-3523

PATIENT INFORMATION:

Patient Name: _____ Date of Birth:_____

Patient Phone: _____ Patient Insurance Plan: _____

QUALIFYING CONDITIONS:
(MUST CHECK AT LEAST ONE)*

- ☐ Neck Pain
- ☐ Back Pain
- ☐ Shoulder Pain
- ☐ Elbow Pain
- ☐ Wrist Pain
- ☐ Hand Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Ankle Pain
- ☐ Foot Pain
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ Vertigo
- ☐ Abnormal Gait
- ☐ General Weakness
- ☐ Post Op Rehab
- ☐ Other: _____ _____

ADDITIONAL CONDITIONS:

- ☐ Chronic Fatigue
- ☐ Insulin Resistance
- ☐ Diabetes
- ☐ Hyperlipidemia
- ☐ Hypoglycemia
- ☐ Hyperglycemia
- ☐ Dysmetabolic Syndrome
- ☐ Impaired Fasting Glucose
- ☐ Hypertension
- ☐ Obesity
- ☐ Weight Gain
- ☐ Patient interested in Weight Loss
- ☐ Other: _____ _____

PLEASE CHECK

- ☐ **PT Evaluate & Treat**
- ☐ **Metabolic Services**
- ☐ Other: _____

Frequency (Times/Wk): 1 2 3 4 5

Duration (Weeks): 1 2 3 4 5 6 7 8

Please visit our website, www.PowellMetabolics.com to view our locations.

Comments/Precautions/Restrictions:

_____

_____

_____

_____

_____ / /
Physician Signature Date

_____
Physician Name (please print)

Patient must have at least one of the above "***Qualifying Conditions***" approved by their health care provider in order to qualify. All "***Additional Conditions***" above are included in the patient's physical therapy treatment as an added benefit. Visit our website for more information.