

Patient Name: _____ Date of Birth: _____ Date: _____

Home Address: _____
Unit City State ZIP

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Diagnosis Code: _____ Description _____

(Please attach patient demographics)

REASON FOR REFERRAL

ORTHOPEDIC

OB/GYN ANTE/POST PARTUM

UROGYNECOLOGY

<input type="checkbox"/>	Sprain / Strain Sacro-iliac Region	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	Stress Incontinence
<input type="checkbox"/>	Backache	<input type="checkbox"/>	Spasm of Muscle or Muscle Weakness	<input type="checkbox"/>	Urge Incontinence
<input type="checkbox"/>	Muscle Spasm / Weakness	<input type="checkbox"/>	Pain in Thoracic Spine / Rib Pain	<input type="checkbox"/>	Urinary Frequency / Urgency
<input type="checkbox"/>	Rotator Cuff Syndrome	<input type="checkbox"/>	Pain in Joint	<input type="checkbox"/>	Mixed Incontinence
<input type="checkbox"/>	Adhesive Capsulitis (shoulder)	<input type="checkbox"/>	Sprain / Strain: _____	<input type="checkbox"/>	Pelvic Floor Muscle Spasm
<input type="checkbox"/>	Stiffness in Joints	<input type="checkbox"/>	Carpal Tunnel Syndrome	<input type="checkbox"/>	Muscle Weakness
<input type="checkbox"/>	Pain in Limb: _____	<input type="checkbox"/>	Scar Pain / Adhesion	<input type="checkbox"/>	Sexual Pain / Dysfunction
<input type="checkbox"/>	Pain in Joint: _____	<input type="checkbox"/>	Diastasis Recti	<input type="checkbox"/>	Chronic Pelvic Pain
<input type="checkbox"/>	Sprain / Strain: _Hip _Knee _Ankle	<input type="checkbox"/>	Blocked Ducts	<input type="checkbox"/>	Scar Pain / Adhesion
<input type="checkbox"/>	Sciatica	<input type="checkbox"/>		<input type="checkbox"/>	Interstitial Cystitis
<input type="checkbox"/>	Difficulty Walking	<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	Scar Pain / Adhesion	<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	Thoracic Outlet Syndrome	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Post Surgical Rehab	<input type="checkbox"/>		<input type="checkbox"/>	

*Mark with an X in front of reason

THERAPY TREATMENT

Evaluation and Treatment

Precautions: _____

Physician's Signature: _____

Physician's Printed Name: _____ Phone: _____ Fax: _____

WELLNESS SERVICES* (Not covered by insurance)

Wellness Coach

Personal Training

Massage Therapy

Other: _____

Date: _____ NPI _____

Please have patient call us and visit our website to download forms to fill out prior to their appointment.

info@BercuttPT.com

BercuttPT.com

PHYSICAL THERAPY

MASSAGE THERAPY

PERSONAL TRAINING

Pam Bercutt is the proud mother of two wonderful boys and has lived in the West U and Bellaire area for over 20 years. She received her Masters in Physical Therapy from Texas Woman's University in 1995 and her Doctorate in 2010. Opening of this clinic is a collaborative effort and would not have happened without the love and support of her family, friends, colleagues and mentors.

"This clinic encompasses my vision of a health and wellness center where the patient and client can come for personalized attention to achieve rehabilitative services to get them back to their sport, to their life and to their next adventure, pain-free with strength and confidence."



PHYSICAL THERAPY

- Orthopedic and Sports Rehab
- Dry Needling for Joint pain and myofascial restrictions
- Post Surgical Rehab
- Pregnancy, Post partum and related disorders
- Pelvic Floor Rehab; sexual pain, chronic pelvic pain and urinary incontinence
- Myofascial release and other manual therapies
- Scar Tissue Relief and Healing

