BACK IN BALANCE wellness center

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www.backinbalancechiro.com

chiropractic • acupuncture • physical therapy • massage therapy • nutrition • corporate wellness

PHYSICIAN REFERRAL FOR INTEGRATIVE CARE

Referring Clinic Name and Address:

_____

_____

_____

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____ SS#: _____

Patient's Condition/Diagnosis: _____ Secondary Diagnosis: _____

- ❑ Neck Pain/Headache/Arm Pain
- ❑ Low Back Pain/Leg Pain/Sciatica
- ❑ Thoracic Pain
- ❑ Disc Injury/Bulge/HNP
- ❑ Mechanical Lower Back Pain
- ❑ Sprain/Strain Injury (C-T-L)
- ❑ Myofascial Pain/Fibromyalgia
- ❑ Facet Joint Dysfunction
- ❑ SI Joint Dysfunction
- ❑ Whiplash/Soft Tissue Injury
- ❑ Thoracic Outlet Syndrome
- ❑ Carpal Tunnel Syndrome
- ❑ Extremity Pain
- ❑ TMJ Disorder
- ❑ Chronic Pain Syndrome
- ❑ Other: _____

_____

_____

This list is not exhaustive but might be useful as a guide. We treat many other conditions not listed on this form.

Please provide the following service(s):

- ❑ Evaluate and Treat\X-ray
- ❑ Consult/Second Opinion Only
- ❑ Spinal Manipulation/Adjustments
- ❑ Myofascial Release
- ❑ Massage Therapy/Soft Tissue/ Trigger Point Therapy
- ❑ Physical Therapy/Therapeutic Modalities
- ❑ Rehabilitation/Functional Capacity Examination
- ❑ Acupuncture
- ❑ Nutritional Analysis
- ❑ ALCAT Food and Chemical Sensitivity Testing
- ❑ Orthotics
- ❑ Number of visits requested or date range: _____
- ❑ Other: _____

_____

_____

_____

Referring Physician's Signature: _____

Date: _____ NPI#: _____

Physician's Name: _____
(Print or Stamp Please)

Referring Physician's Phone Number: _____

Referring Physician's Fax Number: _____

Please have patient hand-deliver this form or return this form to Back in Balance Wellness Center via fax 207.947.3721