EXCELLENCE IN HEALTH
CHIROPRACTIC & REHABILITATION CLINIC

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Patient's Name: _____ Date: _____

Patient's Phone #: _____ Patient's e-mail: _____

Referring Provider (Please Print): _____ Diagnosis: _____

Contraindications and Comments: _____

_____

Evaluate and Treat:

Concussion: ☐ Acute ☐ PCS ☐ Baseline Testing ☐ EEG/ERP Diagnostic Testing

☐ Low Back Pain
☐ Sciatica
☐ Radiculopathy
☐ Neck Pain
☐ Headache
☐ Herniated Disc(s)
☐ Chronic Pain
☐ Extremity Pain / Dysfunction (Please Specify Region): _____
☐ Other: _____

Services:

☐ Massage Therapy / Manual Therapy (Specify Frequency and Duration): ____ time(s) per week for ____ weeks
☐ Intermittent Traction
☐ Independent Medical Evaluation
☐ Joint Manipulation
☐ Therapeutic Exercise
☐ Passive Physiotherapy Modalities
☐ Assess and Treat at Providers Discretion

Referring Provider's Signature: _____ ☐ Please Provide Patient Status Updates

Referring Provider Phone #: _____ Fax #: _____