OPTIMIZE CHIROPRACTIC
Phone: 903.987.0240 Fax: 210-750-3757
2221 H G Mosley PKWY #101 Longview, Tx 75604

RX FOR CHIROPRACTIC CARE: PHYSICIAN REFERRAL

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Preferred Phone #: _____

PATIENT CONDITION

Diagnosis: _____

- ☐ Mechanical Lower Back Pain
- ☐ Sprain / Strain Injury (C-T-L)
- ☐ Myofascial Pain
- ☐ Facet Joint Dysfunction
- ☐ SI Joint Dysfunction
- ☐ Disc Injury / Bulge / HNP
- ☐ Sciatic Neuritis
- ☐ Neck Pain / Whiplash
- ☐ Thoracic Pain
- ☐ Thoracic Outlet Syndrome
- ☐ Fibromyalgia
- ☐ Carpel Tunnel Syndrome
- ☐ Extremity Pain
- ☐ Pregnancy Pains
- ☐ Chronic Pain Syndrome
- ☐ Other: _____

Please provide the following treatment(s):

- ☐ Evaluate and treat per medically necessary
- ☐ Spinal Manipulation
- ☐ Myofascial Release
- ☐ Soft Tissue / Trigger Point Therapy / Massage / Stretching
- ☐ Physical Therapy Modalities
- ☐ Soundwave Therapy/Piezowave
- ☐ Number of visits requested or date range: _____
- ☐ Other: _____

REFERRING PHYSICIAN

Name: _____ Date: _____

Phone #: _____ Email: _____