TOMBALL
CHIROPRACTIC
SPINE AND REHAB CENTER

Patient Referral

Patient Name: ____

Phone #: __________________ Email: ________________________

Diagnosis (if known): ____

Referred by: ____

☐ **EVALUATE & TREAT** ☐ **UPDATED TREATMENT PLAN**

☐ Chiropractic Rehab
☐ Manual Therapy
☐ Core Stabilization
☐ Strengthening (Upper / Lower)
☐ Joint Mobilization (Passive / Active)
☐ Gait Training
☐ Balance Training
☐ Posture Training
☐ Iontophoresis
☐ Taping

☐ Chiropractic Care
☐ Traction (C/S / L/S)
☐ Electrical Stimulation
☐ Ultrasound
☐ Dry Needling
☐ MLS Laser Therapy
☐ Myofascial Release
☐ Cupping
☐ Russian Stimulation
☐ Other ________________

Frequency/Duration ☐ **3x/week** ☐ **2x/week** ☐ **1x/week** **For ______ weeks**

PAIN MANAGEMENT

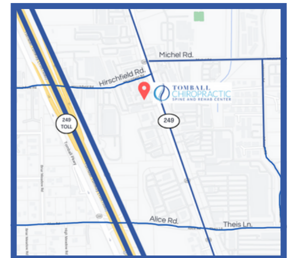
☐ Pain Injections ☐ Regenerative Therapy ☐ TPI ☐ Pharmacotherapy

Special Instructions: ______________________________
____
____

Return to Doctor on: ______________________________

Physician Signature: ______________________________

Date:___________________



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We will gladly take care of scheduling and insurance verification.
Please fax referral with insurance information to the number listed.