

Schaffnit Chiropractic & Rehabilitation

Blake Schaffnit, DC
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Rx for Chiropractic Care: Physician Referral

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Other Phone: _____

Patient's condition: Diagnosis: _____

- | | |
|---|---|
| <input type="checkbox"/> Mechanical lower back pain | <input type="checkbox"/> Thoracic Pain |
| <input type="checkbox"/> Sprain/strain injury (C-T-L) | <input type="checkbox"/> Thoracic Outlet Syndrome |
| <input type="checkbox"/> Myofascial pain | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Facet Joint Dysfunction | <input type="checkbox"/> Carpal Tunnel Syndrome |
| <input type="checkbox"/> SI Joint Dysfunction | <input type="checkbox"/> Extremity Pain |
| <input type="checkbox"/> Disc Injury/Bulge/HNP | <input type="checkbox"/> Pregnancy pains |
| <input type="checkbox"/> Sciatic Neuritis | <input type="checkbox"/> Chronic Pain Syndrome |
| <input type="checkbox"/> Neck Pain/ Whiplash | <input type="checkbox"/> Other: _____ |

Please provide the following service(s):

- Evaluate and treat per medically necessary
- Spinal Manipulation
- Myofascial Release
- Soft tissue/trigger point therapy/Massage/Prenatal Massage
- Physical therapy modalities
- Rehabilitation / Supervised Exercise/Strengthening program
- Number of visits requested or date range: _____.
- Other _____

Referring Physician's Signature: _____ Date: _____

Provider's Name: _____ (please print)

Phone: _____ Fax: _____

- Please send a progress report on completion of treatment

FAX TO (630) 474-9501