Referral Request for Acupuncture

Patient Name ____________________________________ D.O.B._______________
Patient Telephone Number (___________) ______________________________
As the referring PRACTITIONER for the above named patient please select the specialty treatment(s) indicated below:
☐ Acupuncture

Please Select Treatment for Condition(s) Indicated Below:

Pain management
___Headache (Migraine/ Tension/ Sinus) ___Fibromyalgia
___Pain and weakness in (Neck/Shoulders/Back/Abdomen/ Hips/Knees/Legs/Feet/ Hands)
___Muscle cramping ___Sprains, strains ___Sports injuries
___Arthritis ___Bursitis ___Disc problems
___Sciatica ___Carpal Tunnel ___Localized trauma

Neurological
___Facial Paralysis ___Trigeminal neuralgia
___Stroke rehabilitation (Paralysis/ Numbness/ Sensory loss/ Motor impairment)

Digestive
___Irritable bowel syndrome ___Gastric hyperacidity ___Chronic diarrhea
___Chronic constipation ___Bloating ___Nausea

Women's Health
___Irregular Menses ___Menopause ___Uterine fibroids
___Endometriosis ___Infertility ___Overactive bladder
___Morning sickness ___Postpartum recovery

Respiratory
___Sinusitis ___Common Cold ___Allergy
___Bronchitis ___Asthma ___Cough

Emotion
___Depression ___Anxiety ___Anxious

Other Conditions
___Smoking Cessation ___Insomnia
___Others, please specify: ____

Please Indicate Your Preferred Method of Follow-up:

___Phone: (________)________ -________________________
___E-mail: ___________@______________________________
___Fax: (________)________ -________________________
___Mail: ____

Comments____

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Referring practitioner (printed)__________________________ Date _____________

Practitioner signature ____________________________Telephone # ____________

Osmon Chiropractic Center
Kellie Osmon, MS, L.Ac
1332 W. Arch Haven Ave. Ste. C
Bloomington , IN 47403
(812) 333-7447