Cooper Chiropractic & Massage Therapy

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Name_____ Date_____

Diagnosis _____

Goals _____

Precautions _____

SERVICES AVAILABLE

- ❑ Chiropractic Adjustment
  - Spinal
  - Extra Spinal
  - Cranial
  - TMJ
  - Upper extremity/Lower Extremity
- ❑ Therapeutic Exercise
  - Core Stability
  - PNF, Balance
  - Sport Specific
  - Upper Body
  - Lower Body
  - Diastasis Recti evaluation
- ❑ Postural Assessment
- ❑ Kinesio Tape
- ❑ Manual Therapy
  - Joint Mobilization
  - MET
  - Trigger Point
- ❑ Light Therapy
  - Sport Specific
  - Upper Body
  - Lower Body
- ❑ Webster Technique
- ❑ Craniosacral therapy
- ❑ Therapeutic Massage
- ❑ Other_____

TREATMENT PRESCRIBED

❑ Evaluate and Treat

❑ Frequency _____Duration_____

❑ Please call patient to schedule appointment

Patient Phone Number _____

Provider Signature _____

Provider Name (print) _____ Phone Number _____

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Thank you for your referral