

Fax 408-935-8347 Email info@MilpitasSpine.com

40 N. Park Victoria Drive, Suite G Milpitas, CA 95035

Patient's Information

First Name:	Last Name:
Home Phone:	Cell Phone:
Date of Birth:	Male 🗌 Female 🗌
Insurance Carrier:	ID#:
Injury: Auto 🗌 Work 🗌 Over	ruse Sports Other
Referring Doctor	
Office Phone:	Office Fax:
Diagnosis:	
Precautions / Comments:	
Recommendation:	
Frequency: Daily 1x 2x 3x Per Wee	ek Duration: Per/Week
Chiropractic Treatment / Spinal Manipula	ation Per Week or Sessions
Doctor's Signature (Must Be Signed) Complete Rehabilitation Progr	Date ams
Joint Mobilization	☐ Endurance Training
	☐ Flexibility / Stretching
Myofascial Release	☐ Work Conditioning
Active Release Techniques	Dynamic Lumbar Stabilization Training
Massage	Posture and Body Mechanics Education
Neuromuscular Re-Education	ADL Training
Spinal Traction	☐ Gait Training
Range of Motion / Strength Training	☐ Motor Vehicle / Personal
Proprioception / Balance Exercises	☐ Injury Rehabilitation
Ultrasound / Iontopheresis	☐ Traction ☐ Ice/Heat
Electrical Stimulation	☐ Acupuncture