BAYSIDE CHIROPRACTIC, PC
Helping you heal body, mind & spirit naturally

Paul J. O'Brien Jr, DC
Alejandra Torres Lora, DC

Your referral is greatly appreciated. In an effort to provide the best service possible,

please complete the information below. Thank you.

Referring Provider's Name _____

would like to introduce

Patient's Name _____ DOB _____

for evaluation and treatment of a possible chiropractic/cranial disorder.

Please check all areas you wish to have evaluated for your patient:

- ○ Acid Reflux
- ○ Gas Pains
- ○ Colic
- ○ Spit Up
- ○ Constipation
- ○ Tongue-Tie
- ○ Lip-Tie
- ○ Poor Latch
- ○ Feeding Concerns
- ○ Gag Reflex
- ○ Snoring
- ○ Grinding
- ○ TMJ
- ○ Torticollis
- ○ Plagiocephaly
- ○ Hematomas
- ○ Flat Spot
- ○ Tight Muscles

Additional Information or Concerns _____

_____

_____

_____

Patient's Phone # _____

Parent's Name (if patient is a minor) _____

Referring Provider's Signature _____

Provider's Phone # _____ Date _____

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