NAME/ADDRESS of CLINIC/PROVIDER

TREATMENT PLAN OF CARE

_____**Initial Treatment Plan** _____ **Updated Treatment Plan**

Date_____ **Patient** _____ **Patient DOB**_____

Diagnosis/Clinical Impression #1:

_____

_____

Complicated by: _____

Associated with: _____

Resulting in: _____

ICD Codes:

_____

Diagnosis/Clinical Impression #2:

_____

_____

Complicated by: _____

Associated with: _____

Resulting in: _____

ICD Codes:

_____

Recommended Spinal Manipulation Frequency:

Daily _____ 2 x wk _____ 1 x mo _____

3 x wk _____ 1 x wk _____

Therapy:

Type _____ Location _____ Frequency _____ Time _____

Type _____ Location _____ Frequency _____ Time _____

Type_____ Location _____ Frequency _____ Time _____

Rehab:

Cervical: Passive _____ Active _____ General _____

Lumbar: Passive _____ Active _____ General _____

Structural Support:

Cervical Pillow _____ Cervical Collar Soft _____ Firm _____

Lumbar Cushion _____ Lumbar Belt Soft _____ Firm _____

Extremity: Shoulder ____ Elbow ____ Wrist ____ Knee ____ Ankle _____ Other_____

Short Term Goals:

Reassessment _____ week(s)/month(s)

_____ % Improvement within _____ weeks.

Long Term Goals:

_____ % Improvement Other_____

Reports: Yes No Due Date _____ Type: PI WC IME Interim Insurance Special

Follow Up Procedures: Lab _____ Nutrition _____ Supports _____ Exercises_____

X-ray _____

RESTRICTIONS

Bed Rest _____ Guarded Movement _____ Athletic Activity _____

Cervical: Flexion _____ Extension _____ Lateral Flexion _____ Sleeping _____

Lumbar: Sitting _____ Bending _____ Stooping _____ Lifting _____ Other _____

Other Restrictions: _____

Reviewed/Prepared by: Print Name of Provider

Provider Signature _____

NAME/ADDRESS of CLINIC/PROVIDER

TREATMENT PLAN OF CARE

_____ Initial Tx Plan
_____ Updated Tx Plan

Date_____ **Patient** _____ **Patient DOB**_____

SPECIAL INSTRUCTIONS

Home Instructions: Ice_____ Heat_____ Hot Soaking _____ Lying On Back, Legs Up _____
Sleeping Position _____ Cervical Pillow _____ Wearing Supports _____ Auto position _____ Lifting____
Changing Positions: Bed _____ Auto _____ Seated Position _____ Other _____
Pamphlets: Speedy Recovery _____ After Neck Injury _____ Bad Back _____ Other _____
Patient Education: Back School _____ Other _____

PATIENT EMPLOYMENT

Off Work: From _____ To _____ Home: Rest _____ Bed Rest _____ Guarded _____
Light Duty: From _____ To _____ Description _____
Lifting Restrictions: _____ Special _____
Other _____
_____

LIFESTYLE/DIET MODIFICATION/NUTRITIONAL SUPPORT

_____ None Recommended
_____ Recommendations:_____
_____

CONSULTATION

_____ None recommended at this time.

_____ Referral to _____
For:
_____
_____

Scheduled / / Time: : AM/PM
Provider_____
Confirmed with Patient
By _____

ADDITIONAL DIAGNOSTIC TESTING

_____ None recommended at this time
_____ Following additional studies recommended

Diagnostic Imaging
_____ Arthography
_____ Computer Tomography (CT)
_____ Contrast Enhanced CT
_____ Contrast Enhanced MRI
_____ Diagnostic Ultrasound
_____ Discography
_____ Fluoroscopy
_____ Magnetic Resonance Imaging (MRI)
_____ Positive Emission Tomography (PET)
_____ Radionuclide Bone Scan
_____ Thermography
_____ Videofluorography
_____ Other_____
_____ Other_____

Scheduled / / Time: : AM/PM
Provider_____
Confirmed with Patient / /
By_____

Electrodiagnostics
_____ Brain Electrical Activity Mapping
_____ Brain Stem Auditory Evoked Response
_____ Electroencephalography
_____ Electronystagmography
_____ EMG (Needle)
_____ Magnetoencephalography
_____ Nerve Conduction Velocity
_____ Peripheral Electrodiagnostics
_____ Somatosensory Evoked Potential
_____ Surface Electrode EMG
_____ Visual Evoked Response
_____ Other

Rehabilitation
____ Evaluation
____ Referral

Laboratory
_____CBS
_____ESR
_____SMAC12
_____SMAC24
_____Urinalysis (DS)
_____ Urinalysis (Micr)

Profiles
_____Anemia
_____Cardiac
_____Hypertension
_____Joint
_____Lipid
_____ Liver
_____Metabolic Bone
_____Pancreas
_____Pregnancy
_____Skeletal Mus
_____Thyroid
_____Urinary Tract
_____Other

Reviewed/Prepared by: Print Name of Provider

Provider Signature _____