

Chiropractic Treatment Form

Instructions

Please fill out and fax a copy to 952-896-1261. For questions, please call 800-444-5769.

Patient Information

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="text"/>
Patient name Last	First	MI		Patient date of birth (MM DD YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Patient address	City	State	Zip	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Patient insurance ID number	Health plan	Group number		

Provider Information

<input type="text"/>	<input type="text"/>		
1. Name of the billing provider or facility	2. Federal tax ID (TIN) of entity in box #1		
<input type="text"/>	<input type="checkbox"/> MD/DO <input type="checkbox"/> DC <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Both PT and OT <input type="checkbox"/> Home Care <input type="checkbox"/> ATC <input type="checkbox"/> MT <input type="checkbox"/> Other <input type="text"/>		
3. Name and credentials of the individual performing the service(s)			
<input type="text"/>	<input type="text"/>		
4. NPI of entity in box #1	5. Phone number		
<input type="text"/>	<input type="text"/>		
6. Address of the billing provider or facility indicated in box #1	7. City	8. State	9. Zip

Provider Completes This Section

<input type="text"/> Date you want this submission to begin	Cause of Current Episode <input type="checkbox"/> Traumatic <input type="checkbox"/> Unspecified <input type="checkbox"/> Repetitive <input type="checkbox"/> Post- Surgical <input type="checkbox"/> Work Related <input type="checkbox"/> Motor Vehicle	<input type="text"/> Date of Surgery Type of Surgery <input type="checkbox"/> ACL Reconstruction <input type="checkbox"/> Rotator Cuff/Labral Repair <input type="checkbox"/> Tendon Repair <input type="checkbox"/> Spinal Fusion <input type="checkbox"/> Joint Replacement <input type="checkbox"/> Other <input type="text"/>	Diagnosis (IDC code) <i>Please ensure all digits are entered accurately</i> 1. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> 2. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> 3. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> 4. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
Patient Type <input type="checkbox"/> New to your office <input type="checkbox"/> Est'd, new injury <input type="checkbox"/> Est'd, new episode <input type="checkbox"/> Est'd, continuing care	Nature of Condition <input type="checkbox"/> Initial onset (<i>within last 3 months</i>) <input type="checkbox"/> Recurrent (<i>multiple episodes of < 3 months</i>) <input type="checkbox"/> Chronic (<i>continuous duration > 3 months</i>)	DC Only Anticipated CMT level <input type="checkbox"/> 98940 <input type="checkbox"/> 98941 <input type="checkbox"/> 98942 <input type="checkbox"/> 98943	Duration of Treatment <input type="text"/>
			Number of Visits Requested <input type="text"/>

Patient Completes This Section

Symptoms began on <input type="text"/>	Indicate where you have pain or other symptoms <input type="checkbox"/> Neck <input type="checkbox"/> Upper back <input type="checkbox"/> Mid back <input type="checkbox"/> Lower back <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Left Shoulder Other: <input type="text"/>
1. Briefly describe symptoms: _____	
2. When/How did symptoms start? _____	
3. Average pain intensity: Last 24hrs no pain 1 2 3 4 5 6 7 8 9 10 worst pain Past week no pain 1 2 3 4 5 6 7 8 9 10 worst pain	
4. How often do symptoms occur? 1 Constantly (76% - 100% of the time) 2 Frequently (51% - 75% of the time) 3 Occasionally (26% - 50% of the time) 4 Intermittently (0%-25% of the time)	
5. How much have symptoms interfered with usual daily activities? (<i>Including both work outside the home and housework</i>) 1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely	
6. How is your condition changing since care began at this facility? 0 NA - This is the initial visit 1 Much Worse 2 Worse 3 A Little Worse 4 No Change 5 Little Better 6 Better 7 Much Better	
7. In general, would you say your overall health right now is... 1 Excellent 2 Very Good 3 Good 4 Fair 5 Poor	
8. What is your occupation? _____	

Patient Signature: x _____ Date: _____