



HealthChoice Management, Inc.

CHIROPRACTIC CONTINUATION REPORT

Patient Name: _____

Chart No.: _____

Date: _____

Claim No.: _____

Diagnosis: _____

Referring Physician: _____

Last Time Seen: _____

Chiropractic TX frequency recommended by PTP: 1- 2- 3 / week for 3- 4 - 6 weeks, other _____

Present Condition: _____

Regions: _____

Region:	Cervical	Thoracic	Lumbar	R. Shoulder	L. Shoulder	Elbow R/L	Wrist R/L	Hip R/L	Knee R/L	Ankle R/L
Pain intensity	/10	/10	/10	/10	/10	/10	/10	/10	/10	/10

*Pain Intensity Visual Analogue Scale (VAS): (0) No Pain, (10) Severe or Worst Possible Pain

RANGE OF MOTION

MOVEMENT	CERVICAL	THORACIC	LUMBAR	MOVEMENT	R. SHOULDER	L. SHOULDER
Flexion	/50	/45	/90	Flexion	/180	/180
Extension	/60	/0	/25	Extension	/40	/40
R. Lat. Flexion	/45	/45	/35	Abduction	/180	/180
L. Lat Flexion	/45	/45	/35	Adduction	/30	/30
R. Rotation	/80	/30	/45	Int. Rot	/80	/80
L. Rotation	/80	/30	/45	Ext. Rot	/90	/90

MOVEMENT	ELBOW		WRIST		HIP		KNEE		ANKLE	
	R	L	R	L	R	L	R	L	R	L
Flexion	/150	/150	/60	/60	/100	/100	/150	/150	/60	/60
Extension	/0	/0	/60	/60	/30	/30	/0	/0	/40	/40
Abduction			/20	/20	/40	/40				
Adduction			/30	/30	/20	/20				
Int. Rot					/40	/40				
Rot.					/50	/50				
Supination	/80	/80								
Pronation	/80	/80								
Inversion									/30	/30
Eversion									/20	/20

MEDICATION:

Pain Medication _____ is _____ day/week

Pain Medication _____ is _____ day/week

Pain Medication _____ is _____ day/week

Walking (1)	Standing (1)	Sitting (1)	Driving (1)	Sleeping (2)	Using Tools *	Climbing Stairs*	Self-Hygiene*
____mins/ hrs	____mins/ hrs	____mins/ hrs	____mins/ hrs	____ hrs	/5	/5	/5

(1) Time/Distance with little or no pain, (2) Uninterrupted hours of sleeping, (*) Degree of difficulty: 0 (no difficulty) to 5 (severe difficulty).



MEASURABLE GOALS:

- | | |
|--|--|
| ☐ Decrease of pain (Visual Analog Scale, 1-10) | ☐ Increase body mechanics and ability to perform ADL (Activities of Daily Living) |
| ☐ Increase range of motion | ☐ Increase ability to perform job-related duties |
| ☐ Reduce pain medication | ☐ Improve sleep. |
| ☐ Reduce muscle spasms | ☐ Reduce hospital visits or other medical interventions. |
| ☐ Increase strength | ☐ Reduce pain behaviors. |
| ☐ Increase endurance | |
| ☐ Improve tolerance to sitting, walking and standing. | |

FACTORS DELAYING PATIENT'S RECOVERY:

- ☐ Chronic condition ☐ Patient is de-conditioned ☐ Continuance of perpetuating factors: patient continues with same job activities
☐ Patient is not responding to other Pain Management treatments like ☐ pain medication ☐ physical therapy ☐ epidural shots ☐ Surgery
☐ Co-morbidity factors/complications/pre-existing conditions. _____

WORK STATUS:

- ☐ Retired ☐ Not working ☐ Full time ☐ Part time ☐ Without restrictions
☐ Restrictions (Per the Primary Treating Physician) _____

MEDICAL NECESSITY TO CURE OR RELIEVE:

- ☐ Significant improvement can be reasonably expected.
☐ The patient has not reached maximum therapeutic benefit (MTB) or maximum medical improvement (MMI).
☐ There was an exacerbation or flare up of condition
☐ The patient is ☐ unable due to GI intolerance ☐ allergic ☐ addicted ☐ unwilling, to take medication.

COMMENTS:

REQUEST FOR AUTHORIZATION TO INITIATE TREATMENT

Chiropractic treatment frequency recommended by PTP: 1 – 2 – 3 / week for 3 – 4 – 6 – 8 weeks: Total _____

PROVIDER NAME/ SIGNATURE: _____

CLINIC ADDRESS: _____