Chiropractic Network
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HealthChoice Management, Inc.

CHIROPRACTIC INITIAL REPORT

Patient Name:_____ **Chart No.:** _____ **Date:**_____
Claim No.: _____ **Diagnosis:**_____
Referring Physician: _____ _____
Follow up appointment:_____

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

Previous/Current Treatment/s:

- **Pool Therapy---------- 1 - 2 - 3 / week for 4 - 6 - 8 weeks; improved: yes, no, temporary relief, discontinued**
- **Acupuncture---------- 1 - 2 - 3 / week for 4 - 6 - 8 weeks; improved: yes, no, temporary relief, discontinued**
- **Physical Therapy---------- 1 - 2 - 3 / week for 4 - 6 - 8 weeks; improved: yes, no, temporary relief, discontinued**
- **Exercise Program---------- 1 - 2 - 3 / week for 4 - 6 - 8 weeks; improved: yes, no, temporary relief, discontinued**
- **Home Exercise Program (HEP)---------- improved: yes, no, discontinued**
- **Epidural/s: 1 - 2 – 3 (_____) improved: yes, no, temporary relief**
- **Surgery:** _____**(**_____**), improved: yes, no**
- **None**

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
Flexion	/50	/45	/90
Extension	/60	/0	/25
R. Lat. Flexion	/45	/45	/35
L. Lat Flexion	/45	/45	/35
R. Rotation	/80	/30	/45
L. Rotation	/80	/30	/45

MOVEMENT	R. SHOULDER	L. SHOULDER
Flexion	/180	/180
Extension	/40	/40
Abduction	/180	/180
Adduction	/30	/30
Int. Rot	/80	/80
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

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	Walking (1)	Standing (1)	Sitting (1)	Driving (1)	Sleeping (2)	Using Tools*	Climbing Stairs*	Self-Hygiene*
Initial Evaluation	___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 range of motion
- ☐ Reduce pain medication
- ☐ Reduce muscle spasms
- ☐ Increase strength
- ☐ Increase endurance
- ☐ Improve tolerance to sitting, walking and standing.
- ☐ Increase body mechanics and ability to perform ADL (Activities of Daily Living)
- ☐ Increase ability to perform job-related duties
- ☐ Improve sleep.
- ☐ Reduce hospital visits or other medical interventions.
- ☐ Reduce pain behaviors.

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: _____