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Last Revised 10.20.15

SOTERIA HEALTHCARE NETWORK®

FORM 1

:: INITIAL ::
CHIROPRACTIC TREATMENT PLAN FORM

Date: _____ **Treating Doctor:** _____

Telephone: _____ **Fax:** _____

PLEASE TYPE OR PRINT CLEARLY. NOTE: If all answers are not complete and accurate, this form will be returned without authorization. This form is required if the patient's condition requires care beyond one visit. Additional information may be required upon request.

Patient Name: _____ **DOB:** _____ **Sex:** _____

Member ID # _____ **Health Plan Name** _____ **Employer** _____

THIS CASE IS: Group Health ___ **Work Comp** ____ **Auto Liability** ___

Is Kaiser Permanente the patient's PRIMARY INSURANCE CARRIER? Yes ____ No ____
Is Patient A Dependent? Yes ____ No ____
NOTE: A Signed Primary Payor Information Form Must Be Submitted.

1. List ALL Diagnoses For Which You Have Treated This Patient In The Past 12 Months:

ALL Diagnoses (Past 12 Mos.):	ICD-10 Code:	# of Treatments:	Dates:
_____	_____	_____	From _____ To _____
_____	_____	_____	From _____ To _____
_____	_____	_____	From _____ To _____
_____	_____	_____	From _____ To _____
_____	_____	_____	From _____ To _____
_____	_____	_____	From _____ To _____
_____	_____	_____	From _____ To _____

2. Current Diagnoses:

_____ ICD-10 Code _____
_____ ICD-10 Code _____
_____ ICD-10 Code _____

3. Date When Current Condition Began: _____

4. Etiology Or Cause Of Current Condition: _____

_____

5. Date of First Visit For Current Course of Treatment: _____

6. Current Subjective Complaints:

a) _____ **b)** _____
c) _____ **d)** _____

7. Positive Tests Which Confirm Your Diagnosis:

b) _____ **b)** _____
c) _____ **d)** _____

8. Visit Estimate To Complete Acute Phase of Treatment: # of Visits _____ **Over** _____ **Days Or** _____ **Weeks.**

9. On a Scale of 1 to 10 – What is the Patient's Current Pain Level: _____

10. Prognosis: _____

11. Additional Doctor Comments (Optional) _____

Doctor's Signature:

_____ **Date:** _____