Soteria Healthcare Network UM Department
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FORM II

:: FOLLOW UP ::
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 _____________

2. Current Diagnoses:

____ ICD-10 Code _______________________________
____ ICD-10 Code _______________________________
____ ICD-10 Code _______________________________

3. Date When Current Condition Began (If submitting for continuing care of an acute episode, use data collected at time of initial exam).:
____

4. Etiology Or Cause Of Current Condition (A. State reason for request of additional visits. B. Etiliogy, Cause of Current Condition, or Exacerbation, if applicable).: ____

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

6. Have You Completed The Acute Phase of Treatment? _________________ **If Not, Date of Projected Completion** ____________________

7. On A Scale of 1 To 10 - What Was/Is Patient's: Initial Pain Level ___________________ **Current Pain Level** ______________________

8. Percentage of Patient Recovery To Date? ____

9. Current Subjective Complaints:
a) ____ b) ____
c) ____ d) ____

10. Positive Tests Which Support Your Request For Additional Treatment:
a) ____ b) ____
c) ____ d) ____

11. Number of Additional Visits Requested ____________________ **Over**____________________**Days Or** ____________________ **Weeks.**

12. Have You Placed The Patient On Specific Recommendations/Limitations? Describe. ____

13. Has The Patient Been Compliant? ____

14. Describe The Home Exercise Or Therapy Advised ____

15. Is There Anything About This Case That Makes It Unusual Or That May Hinder Your Progress?
____

16. Additional Doctor Comments (Please Use Attached Sheet) ____

17. **Doctor's Signature** ____ **Date:** ______________________________________