



**:: 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 Dependant? 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: \_\_\_\_\_