



:: 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 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 _____

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. Etiology, 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: _____