MEDICAL ASSOCIATES HEALTH PLANS®

Medical Associates Health Plans and Health Choices
Chiropractic Treatment Plan

HEALTH CHOICES

Patient First Name: _____ Last Name: _____ DOB: _____ ID# _____

Chief Complaint

Chief Complaint: _____

Initial Date of Service: _____ Date of onset/exacerbation for this diagnosis: _____

Reason for Treatment:
_____ Accident _____ Illness _____Injury _____Work Related _____Other

Diagnosis Code(s): Primary _____ Secondary: _____

Exam Findings

Chief Complaint: __C __T __L __Pelvis __Sac __Ext __Pain __Stiffness __Paresthesia
__ Spasms __ Decreased ROM __Edema __ Muscle Hypertonicity
__ Radiating Pain __Other (explain) _____

Functional Deficits: __Personal Care __Lifting __Walking __Sitting __Standing __Work
__ Sleep Disturbance __Driving __Other (explain) _____

Neurological Findings: __Normal ___Other (explain) _____

Treatment

Treatment Requested:
_____ Spinal manipulation
_____ Physiotherapy (ultrasound, ice, etc.)
_____ Acupuncture
_____ Therapeutic Exercises
_____ Other (specify) _____

Home/Self Care Recommendations: __Ice __Moist Heat __ Home exercises __Other (explain)
_____

Treatment Plan

***** Up to 30 days of treatment may be requested*****
New evaluation and treatment plan required every 4 week of care.
*****If a patient is not improving, please refer to M.D./D.O. for further evaluation*****

Treatment Plan: _____ Visits/week for _____weeks, from _____ to _____
_____ Visits/week for _____ weeks, from _____ to _____

Total # of CMT: _____
Treatment Goals: _____
Released (Discharged) from this episode of care on _____

Provider Signature: _____

Contact Info: Phone _____ Fax: _____ Email: _____

Return Address: _____
Address City, State, Zip

1605 Associates Drive, Suite 101 Dubuque, IA 52004-5002
Phone: (800) 325-7442 or (563) 584-3275
Fax: (563) 584-4893