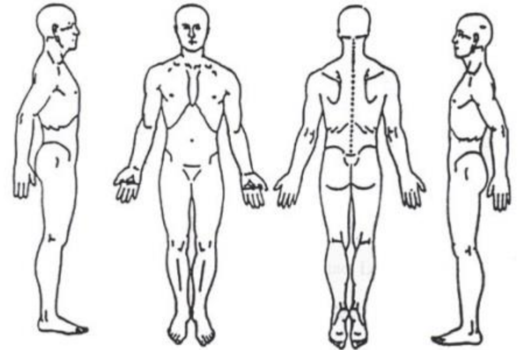
Chiropractic Assessment & Treatment Form

Patient Name: ____



Please list your symptoms below and the relative pain intensity (0-10) for each symptom:

No Pain		**Mild**		**Moderate**		**Severe**		**Unbearable**	
0	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Symptoms (example: Low Back Pain):

1) ______________________ 3) ______________________

2) ______________________ 4) ______________________

The following activities cause me pain: ❑ Sitting ❑ Standing ❑ Lifting ❑ Bending ❑ Pulling

Have you had any medial branch blocks, epidurals, or radiofrequency ablations? ❑ Yes ❑ No

If Yes, when: ____

Signing below indicates that the above information is true and gives the doctor permission to treat me:

Patient Signature: ____ **Date**:___________

Do Not Write Below This Line

Progress Assessment: ❑ Improving ❑ Improving-slowly ❑ Exacerbation ❑ Unchanged ❑ Worse

Complying with home exercise therapy: ❑ Yes ❑ No | Tolerates Treatment Well: ❑ Yes ❑ No

Today's Procedure: 97110 X____

❑ Assisted Stretch: 8-15min | Regainer Chair 8-15min | Wobble Chair 8-15 min | Precor 8-15 min | E-stim 8-15min | Wobble Board 8-15min | Wall Traction 8-15min |

Strapping: ❑ Thoracic Shoulder (RT) (LT) ❑ Lumbar Hip (RT) (LT) ❑ Other: _________________

Objective Findings:

C1 C2 C3 C4 C5 C6 C7 T1 T2 T3 T4 T5 T6 T7 T8 T9 Tl0 T11 T12 L1 L2 L3 L4 L5 SAC PELVIS

RSI LSI SHOULDER WRIST ELBOW KNEE ANKLE RT/LT

INST________ DIV__________ DROP__________

Ortho Tests: ____

Deceased ROM: ❑ Yes ❑ No | Edema: ❑ No ❑ Yes Area ______________________

Palpation:

Spasm: ❑ No ❑ Yes Area _________________ Hypertonicity: ❑ No ❑ Yes Area ________________

Tenderness: ❑ No ❑ Yes Area: C T L Other: ____

Diagnosis: 1) _________________ 2) _________________ 3) _________________ 4) _________________

Provider Signature ____ Date_____________ R/S______