

Insureds Employer Network

Patient's relationship to insured: Self Spouse Child

Patient's First Name MI Last Name

Primary Insureds First Name MI Last Name

Patient Occupation Birthdate Male Insurance ID Number

Date of onset Date of first visit Date most recent visit Female Primary Insurance Secondary Insurance

History

Original Area of Complaint

Cervical Thoracic Lumbar Pelvic Sacral
 Upper extremity R L Lower extremity R L

Current Area of Complaint

Cervical Thoracic Lumbar Pelvic Sacral
 Upper extremity R L Lower extremity R L

Original Diagnosis Codes:

Current Diagnosis Codes:

Original Pain Scale: 0 = no pain, 10 = constant, debilitating pain:

Current Pain Scale: 0 = no pain, 10 = constant, debilitating pain:

Percentage of overall improvement

Original Findings:

Muscle Soreness
 Muscle spasm
 Pos. Orthopedic findings
 Hypo/Hyperesthesia
 Pos. Neurological findings
 Pre-existing condition
 Degenerative changes

Current Findings:

Muscle Soreness
 Muscle spasm
 Pos. Orthopedic findings
 Hypo/Hyperesthesia
 Pos. Neurological findings
 Pre-existing condition
 Degenerative changes

Original Restriction Cervical Lumbar Extremity

5 to 15%
 16 to 30%
 31 to 50%
 51 to 75%
 76 to 100%

Current Restriction Cervical Lumbar Extremity

5 to 15%
 16 to 30%
 31 to 50%
 51 to 75%
 76 to 100%

Referral to another specialty? Yes No

If yes, please indicate specialty and physicians name below:

Orthopedic/Neurological Test (mark if positive)

Straight Leg Raise	R +	L +	Pain only
Ely	R +	L +	Pain only
Fabere	R +	L +	Pain only
Soto Hall	R +	L +	Pain only
Foraminal Compression	R +	L +	Pain only

Current Condition:

Treatment Plan:

Total treatments for this injury:

To Date: Additional Requested:

If there are extenuating circumstances which have increased the need for care please describe below:

Type of Treatment (List Codes):

Exam	99202	99203	99211	99212	99213
Treatment	98940	98941	98942		

Therapy: Target Tissue:

List Therapies Used

Home Treatment & Treatment Goals:

Doctor's Signature Date

Doctors' full name

Tax ID or Social Security No.

Phone Number Fax Number

Patient Pain Drawing

Date: _____ Patient Name: _____ Patient I.D. No.: _____

Please have the patient draw the location of his/her pain or discomfort on the images below.

Use the following symbols to represent the type(s) of pain:

D = Dull

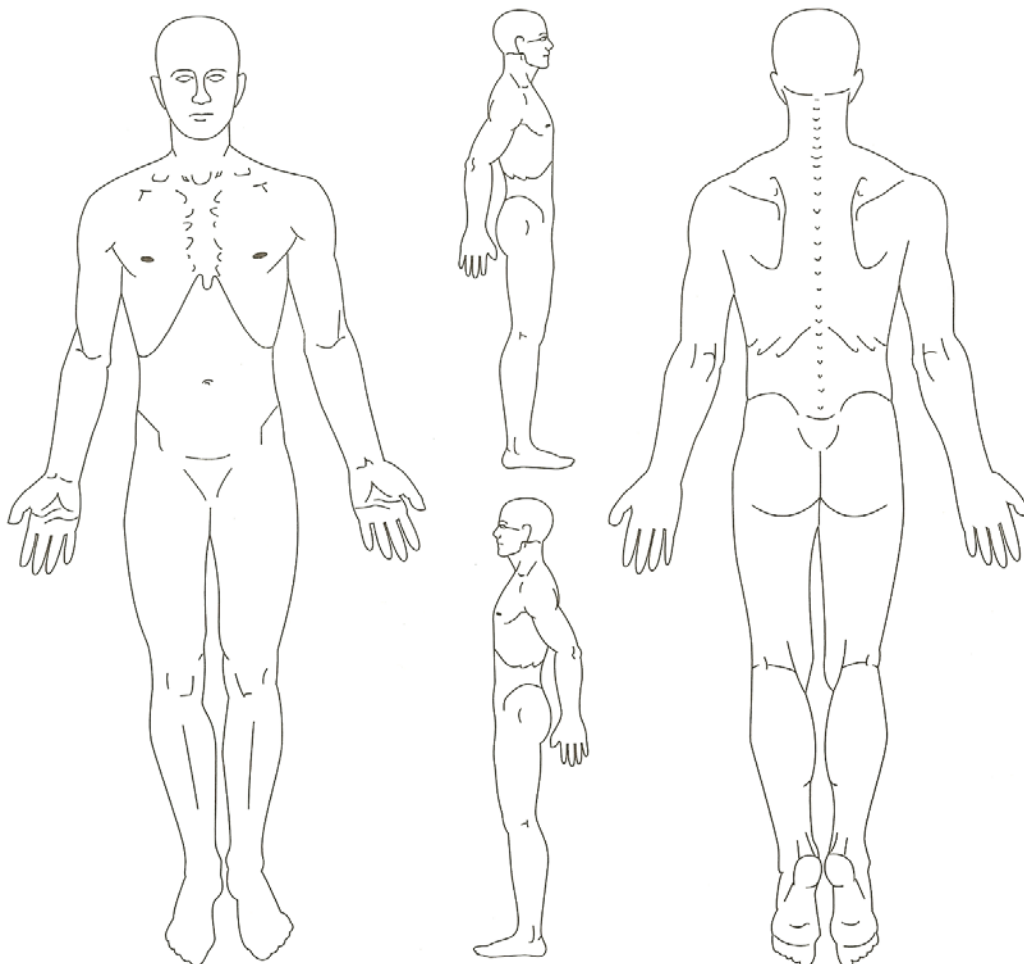
S = Stabbing/Cutting

B = Burning

T = Tingling (Pins & Needles)

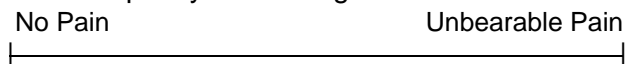
N = Numb

C = Cramping

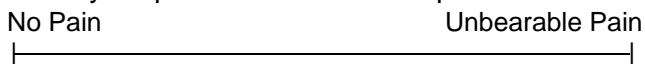


On the Scales Below, Please draw a vertical line representing your pain or discomfort:

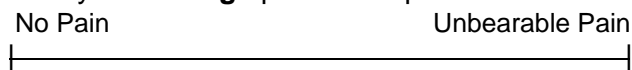
Rate the pain you have right **now**:



Rate your pain at its **best** in the past week:



Rate your **average** pain in the past week:



Rate your **worst** pain in the past week:

