DC PATIENT MANAGEMENT FOLLOW-UP FORM

Patient Information

_____

Age: _____ **Sex:** ☐ Male ☐ Female

_____

_____ _____ _____

_____

Date of first visit:

_____

Physician

_____

_____

_____

_____ _____ _____

P: _____ **F:** _____

Diagnosis / Clinical Impression

Original Diagnosis:

Revised Diagnosis:

Treatment Outcome

Please X appropriate box(es). Add additional information if required.

☐ **Patient Discharged**

- ☐ Signs / symptoms resolved
- ☐ Maximum therapeutic benefit attained
- ☐ Signs / symptoms unchanged
- ☐ Referred to physician
- ☐ Inappropriate for care

☐ **Care is ongoing:**

- ☐ Patient is improving but maximum therapeutic benefit not yet attained.
- ☐ Patient is stable and care to be provided as necessary

Revised plan of management:

- ☐ Manipulation
- ☐ Mobilization
- ☐ Soft tissue therapy
- ☐ Exercise program
- ☐ Education
- ☐ Other: _____

_____

Treatment Frequency / Duration:

- ☐ / Week
- ☐ For weeks

Reassessment Period:

- ☐ In weeks
- ☐ For weeks

Comments / Suggestions

Chiropractor: _____

_____

_____ _____ _____

Signature: _____ **Date** _____