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YOUR INITIAL TREATMENT PLAN

Patient's Name _____ **Date** _____

CLINICAL IMPRESSION:

Subluxated Areas	Cervical Spine ❑ Thoracic Spine ❑ Lumbar Spine ❑ Sacrum ❑ Pelvis ❑	Shoulder ❑ Elbow❑ Wrist ❑ Hand ❑ Hip ❑ Knee ❑ Ankle ❑ Foot ❑ TMJ ❑
Condition(s)/Diagnosis		
Problems to be Monitored		

OUR IMPRESSION OF ANY APPARENT RISKS TO STANDARD CHIROPRACTIC CARE:

POSSIBLE RISK		COMMENTS
Osteoporosis	❑	
Vascular	❑	
Stability	❑	
Neurological	❑	
Inflammatory Condition	❑	
Prior Adverse Reaction	❑	
Medications	❑	
Other	❑	

If there is a perceived risk, our recommendations for modification/alternatives for your care:

RECOMMENDATIONS FOR TREATMENT:

Date: / / **Phase 1 Tx Freq. = times ❑ wk ❑ mo. Duration = ❑ wk ❑ mo.**
Phase 2 Tx Freq. = times ❑ wk ❑ mo. Duration = ❑ wk ❑ mo.

CHIROPRACTIC TECHNIQUES USED

❑ Diversified Technique ❑ Gonstead ❑ Activator ❑ Sacral-Occipital Technique
❑ Flexion-Traction ❑ Thompson Drop Table Technique ❑ Toggle Recoil Technique
❑ Other

PHYSIOTHERAPY USED

❑ US-pulse ❑ US-cont ❑ US-combo
❑ MM-Stim ❑ INTF ❑ Heat/Cold
❑ PNF ❑ Exercise ❑ MRT/ STM/TP

RECOMMENDATIONS FOR WORK AND OR HOME CARE

Avoid:

Do:

DOCTOR'S SIGNATURE _____ **DATE**_____

PATIENT SIGNATURE _____ **DATE** _____