Ohio State Chiropractic Association
172 E State Street, Ste 502, Columbus, OH 43215
(614) 229-5290 (p) ~ (614) 229-5296 (f)

Treatment Plan Report

Patient Name: ____ Visit Date: ______________

○ Initial ○ Update ○ Exacerbation ○ Progress #: _____

Subjective and Objective Findings:
See *plug in the names of any documents you use that have health history and objective findings on them*

Diagnosis:
See *Working Diagnosis Sheet* (or whatever form you use that records Dxs.)

Assessment of Patient Condition:
I feel this patient's condition is (mild / moderate / severe / extremely severe), will respond favorably to chiropractic care, and that a reasonable expectation for functional improvement exists.

Care Plan:
I am conditionally accepting this patient for a (trial / follow-up) period of care to consist of:

- _____ visits a week for _____ weeks(s) at the conclusion of these visits I will be re-evaluating the patient to monitor treatment effectiveness and modify the treatment plan as necessary at that time.

Statement of Medical Necessity:
Please be advised that the specific procedures listed below are medically necessary based on this patient's history, examination, and diagnosis; and are needed to ensure effective care. (Note: only those procedures marked will be administered.)

- **Chiropractic manipulative treatment** (9894__) will be administered to the ____ spinal region(s) due to findings noted in the most recent examination of segmental dysfunction. This will be performed to influence joint and neurophysiological function and will be administered for 12 consecutive visits.

- **Extremity manipulative treatment** (98943) will be administered to the ______________________________ due to findings of pain and _________________________ noted in the most recent examination. This will be performed to influence joint and neurophysiological function. Treatment will be administered for the next 12 visits.

Goals of Care:	**Target Function**	**Current Function**	**Improvement**
o Walking	______________________	______________________	Y / N
o Sleeping	______________________	______________________	Y / N
o Standing	______________________	______________________	Y / N
o Lifting	______________________	______________________	Y / N
o Bending	______________________	______________________	Y / N
o Lying	______________________	______________________	Y / N
o Sitting	______________________	______________________	Y / N

Time Frame to Achieve Goals:
We hope to achieve care plan goals by the aforementioned target dates. Our daily notes will indicate effectiveness from a treatment to treatment basis but the overall care effectiveness will be evaluated at the completion of the next evaluation. Outcome assessment questionnaires may also be used as a tool to determine treatment effectiveness.

______________________________________ Date: _______________

Dr. Somebody