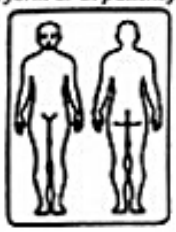
Medicare Initial Visit Form

Medicare Initial Visit Compliance Guidelines

P.A.R.T. **Pain/tenderness** **Asymmetry/misalignment** **Range of Motion abnormality** **Tissue/tone changes**

Patient Name_____ Patient ID# _____ Date of Initial Visit: _____

History/Description of Present Illness: *Note: * indicates additional information is available on reverse of form or in patient file.*



1. Patient Symptoms *(and/or indicate on diagram)*: _____
2. Family History *(if relevant)*: _____
3. Related Past Health History/Surgery/Medications: _____
4. Mechanism of Trauma: _____
5. Quality/Character of Symptoms: *Sharp Dull Aching Shooting Numbness Other*: _____
6. Onset: _____ Duration: _____

Rate Intensity of Pain/Symptoms: *No Pain* 1 2 3 4 5 6 7 8 9 10 *Worst Pain Ever*

Frequency: _____ Location/Symptomatic Radiations: *Refer to #1 above*

7. Aggravating Factors: _____ Relieving Factors: _____
8. Prior Care: _____ Secondary Complaints: _____

Physical Examination: *Note: * indicates additional information is available on reverse of form or in patient file.*

Significant Exam Findings: _____

_____

_____

_____ Date of X-Ray _____

Diagnosis: Subluxation Level(s): C _____ T _____ L _____ S _____ Other: _____

_____

Treatment Plan: _____ Spinal Manipulative Therapy (specific adjustments) _____ Soft Tissue Therapy and/or stretching

_____ Home Care Recommendations: ___ Ice ___ Heat ___ Rest ___ Avoid Aggravating Factors ___ Other: _____

_____ Supports: _____ _____ Cervical

_____ Lumbar _____ _____ Other:

_____ Exercises - *Specify*: _____ Supplements - *Specify*: _____

_____ Ancillary Modalities - *Specify*: _____ Additional notes/forms in file: Yes No

Frequency of Visits: _____ Expected Duration: _____

Treatment Goals: ___ Symptomatic/Pain Reduction ___ Improved Range of Motion ___ Reduced Myofascial Involvement

___ Other Goal(s) - *Specify*: _____

Objective Measures (to evaluate treatment effectiveness): __ Diagnostic Imaging ___ Examination Findings ___ R.O.M.

___ Progress Evaluations ___ Palpation ___ Instrumentation ___ Other - *Specify*: _____

Initial Treatment Date: _____ , 20___ *Data above is provided to comply with Medicare requirements*

Signature: _____ Printed Name: _____

Address: _____ City _____

State: _____ Zipcode: _____ Clinic: _____