

Conservative Treatment History Form

There is significant value in conservative treatment. It is also important to document and for any provider to document recent efforts before establishing further tests and or treatment.

Please type or print clearly. Upload this document via the RadMD Upload Feature. Instructions for how to submit clinical information may be found on the RadMD.com homepage under References. Processing may be delayed if information submitted is illegible or incomplete.

Today's Date:	Patient Name:
Tracking Number:	Date of Birth:
Clinical Questions?	
Has the patient had these symptoms for six months or more?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If no to the above, how long has the patient had these symptoms?	
Has the patient attempted any inactive components of conservative care? (Rest, activity modification, pain meds, injections, steroids or brace etc.)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is this request related to concern for infection or abscess based on Labs, fever, physical exam findings or prior imaging such as Xray or US?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the Patient have known or suspected malignancy or mass?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is this request related to Pre-Operative planning with planned surgery?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the patient have a diagnosis of Multiple Sclerosis or Does the patient have suspected demyelinating disease based on signs/symptoms?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the patient have documented recent trauma with known or suspected fracture?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you tried any of the following active treatments?	
Chiropractic care?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Physical Therapy?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Physician supervised home exercises for this problem?	<input type="checkbox"/> YES <input type="checkbox"/> NO
For which spinal area has therapy been completed?	<input type="checkbox"/> C-SPINE <input type="checkbox"/> T-SPINE <input type="checkbox"/> L-SPINE
For Which Joint has therapy been completed?	<input type="checkbox"/> SHOULDER <input type="checkbox"/> KNEE <input type="checkbox"/> HIP <input type="checkbox"/> ELBOW <input type="checkbox"/> WRIST <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> HAND <input type="checkbox"/> OTHER
If yes to <i>chiropractic</i> care, please complete this section.	
Chiropractic treatment start date? _____ Date of last session? _____	
How many sessions? _____ How does patient feel after doing the therapy? <input type="checkbox"/> BETTER <input type="checkbox"/> SAME <input type="checkbox"/> WORSE	
If yes to <i>physical therapy</i> , please complete this section.	
Physical Therapy start date? _____ Date of last session? _____	
What type(s) of exercises/modalities? _____	
How many sessions? _____ How does the patient feel after doing the therapy? <input type="checkbox"/> BETTER <input type="checkbox"/> SAME <input type="checkbox"/> WORSE	
If yes to <i>physician supervised home exercises</i> , please complete this section.	

Name of supervising Physician? _____

What type of exercises? _____

Who gave you the exercise plan? _____

Home exercise program start date? _____ Date of last session? _____

How many times per week does the patient perform the physician recommended exercise? _____

What was the date of in office physician reassessment when failure was determined? _____

How does the patient feel after doing the supervised home therapy? BETTER SAME WORSE

By making this submission I attest, either as the ordering provider or as authorized by the ordering provider, that all statements made herein are true and verified by specific documentation in the medical record of the applicable patient, and I/the ordering provider understand(s) that misrepresentations made in this submission may be investigated for fraud and/or abuse.

I attest that standard initial clinical workup (physical examination, laboratory testing, and review of prior abnormal imaging reports) has been completed and treatment has failed to improve the patient's clinical condition.

I ATTEST I DO NOT ATTEST

Patient Name

Provider Signature or Individual Completing Form on Behalf of Provider