Conservative Treatment History Form

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

The information in this form will capture conservative treatment history in the event **advanced imaging** needs to be requested. For other procedures, a different form might be needed.

Please print clearly.

Today's Date:	Patient:	Date of Birth:

Think about why you are seeing your provider today. Have you had these symptoms for six months or more?	☐ **YES** ☐ **NO**
If no to the above, how long have you had these symptoms?	

Have you tried any of the following treatments?

Rest / changes or limiting your activity?	☐ **YES** ☐ **NO**
Heat or ice?	☐ **HEAT** ☐ **ICE** ☐ **BOTH**
Physical Therapy?	☐ **YES** ☐ **NO**

If yes to physical therapy, please complete this section.

What was the month and year you started? _____ What was the month and year you had your last session? _____

How many sessions? _____ How do you feel after doing the therapy? ☐ **BETTER** ☐ **SAME** ☐ **WORSE**

Physician recommended home exercises for this problem?	☐ **YES** ☐ **NO**

If yes to physician recommended home exercises, please complete this section.

What type of exercises? _____ Who gave you the exercise plan? _____

What was the month and year you started? _____ What was the month and year you had your last session? _____

How many times per week do you exercise? _____

Medications for this problem like over the counter anti-inflammatory or pain medications (ibuprofen, Tylenol) or narcotics?	☐ **YES** ☐ **NO** If yes, have you been taking them for 3 or more months? ☐ **YES** ☐ **NO**

Signatures

This completed, signed form will be part of the patient's medical record. When history of conservative treatment is required, this form or all information requested herein, should be supplied.

Patient	Provider