Conservative Treatment History Form (Hip/Knee/Shoulder)

Conservative treatment provides significant clinical value to patients who are experiencing joint issues. As such, proper documentation of recent efforts at conservative care is crucial to establishing the need for further treatment or surgery.

IMPORTANT: Please type or print CLEARLY. Once completed and attested, upload this document via RadMD. Processing may be delayed if information submitted is illegible or incomplete.

Today's Date: Tracking Number:	Patient Name: Date of Birth:
Clinical Questions:	
How long has the patient had these symptoms?	
Do the symptoms interfere with Activities of Daily Living (ADLs)?	☐ **YES** ☐ **NO**
Conservative treatments tried for the problem:	
Has the patient had physical therapy?	☐ **YES** ☐ **NO**
If yes to *physical therapy*, please complete this section. Physical therapy start date: _____ Date of last session: _____ Number of sessions completed: _____ How did the patient feel after/during the therapy intervention? ☐ **BETTER** ☐ **SAME** ☐ **WORSE** Is there a medical reason the patient was unable to continue therapy? ☐ **YES** ☐ **NO**	
Has the patient performed a physician-directed home exercise program (HEP)?	☐ **YES** ☐ **NO**
If yes to *physician-directed home exercise program*, please complete this section. Type of exercises: _____ Date when patient started home exercise program: _____ Date of last session: _____ Frequency and duration of the exercises performed (how many times per week and for how long): _____ How did the patient feel after/during the home exercises? ☐ **BETTER** ☐ **SAME** ☐ **WORSE** Is there a medical reason the patient was unable to continue their HEP? ☐ **YES** ☐ **NO**	
Has the patient had a Cortisone injection or Viscosupplementation?	☐ **YES** ☐ **NO**
If yes to *injections*, please complete this section. Type of injection: _____ Date(s) of injection(s): _____	
Has the patient taken anti-inflammatory or pain medications?	☐ **YES** ☐ **NO**
If yes to *medications*, please complete this section. Medication name: _____ Has the patient taken the medication for at least 3 months? ☐ **YES** ☐ **NO**	

Has the patient tried any of the additional treatments below?	
Ambulatory aides ☐ **YES** ☐ **NO**	Type: _____ Duration: _____
Weight reduction ☐ **YES** ☐ **NO**	Number of pounds lost: _____
Activity modification ☐ **YES** ☐ **NO**	Duration: _____
Bracing ☐ **YES** ☐ **NO**	Type: _____ Duration: _____
Ice/heat ☐ **YES** ☐ **NO**	Duration: _____

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

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.

_____

Provider Signature (Please Print and Sign)