



Initial

Kathy's Chiropractic Heaven  
Dr. Katherine M Chang  
1122 Sample Ave  
Denver, CO 80126  
(888) 820-7778

### TREATMENT PLAN

Patient's Name: Todd Patient Patient #: DCE 456  
Date this Episode Began: 11/5/15 Projected Completion of this Treatment Plan: 12/5/15 -> 1/15/16

#1 Complaint:  C  T  L  Pelvis  Sac  Ext  Pain  Stiffness  Paresthesia  Spasms  Decreased ROM  Edema  Muscle Hypertonicity  
 Other: \_\_\_\_\_  
Patient complains of: Pain + stiffness posterior neck

Functional Deficit Noted:  Personal Care  Lifting  Walking  Sitting  Standing  Work  Driving  Other: \_\_\_\_\_  
Inability to: work at computers for longer than an hour Diagnosis: Cervicalgia  
Functional Treatment Goal: Able to work at computers full 8hr day by 1/15/16

#2 Complaint:  C  T  L  Pelvis  Sac  Ext  Pain  Stiffness  Paresthesia  Spasms  Decreased ROM  Edema  Muscle Hypertonicity  
 Other: \_\_\_\_\_  
Patient complains of: \_\_\_\_\_

Functional Deficit Noted:  Personal Care  Lifting  Walking  Sitting  Standing  Work  Driving  Other: \_\_\_\_\_  
Inability to: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
Functional Treatment Goal: Able to \_\_\_\_\_ by \_\_\_\_\_

#3 Complaint:  C  T  L  Pelvis  Sac  Ext  Pain  Stiffness  Paresthesia  Spasms  Decreased ROM  Edema  Muscle Hypertonicity  
 Other: \_\_\_\_\_  
Patient complains of: \_\_\_\_\_

Functional Deficit Noted:  Personal Care  Lifting  Walking  Sitting  Standing  Work  Driving  Other: \_\_\_\_\_  
Inability to: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
Functional Treatment Goal: Able to \_\_\_\_\_ by \_\_\_\_\_

Treatment Plan: Matching each complaint noted above : #1 #2 #3 #4 (including estimated number of units/visits i.e. for CMT it may be visits, but for TherEx it may be units)

Estimated # units this period					Estimated # units this period					Estimated # units this period							
<input checked="" type="checkbox"/> CMT	<u>18-24</u> units	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input checked="" type="checkbox"/> U/S	<u>6</u> units	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> Rehab 1	_____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Technique	<u>DIV</u>					<input type="checkbox"/> Traction	_____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> Rehab 2	_____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
<input type="checkbox"/> CMT-Ext	_____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> Man Therapy	_____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> Rehab 3	_____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
<input type="checkbox"/> Hot+Cold	_____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> Massage	_____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> Other	_____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
<input type="checkbox"/> EMS	_____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> Thera Ex	_____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> Other	_____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

Frequency/Duration this period:  5 Visits X \_\_\_\_\_ Weeks  4 Visits X \_\_\_\_\_ Weeks  3 Visits X 4 Weeks  2 Visits X \_\_\_\_\_ Weeks  
 1 Visit X \_\_\_\_\_ Weeks  2 Visits X \_\_\_\_\_ Monthly  1 Visit X \_\_\_\_\_ Monthly

Complicating factors:  Obesity/Overweight  Diabetes  Other: none / desk job  
 Contraindications for Care: none

Home / Self Care Recommendations:  Ice  Moist Heat  Home Exercises per Instruction  Other: \_\_\_\_\_  
Other Recommendations:  C Pillow  L Pillow  Orthotics  Analgesic  Support/Brace \_\_\_\_\_  Rehab Equip \_\_\_\_\_  Nutrition \_\_\_\_\_  
 Add'l DX Testing \_\_\_\_\_  Other: \_\_\_\_\_

Long Term Goal:  Attain pre-condition/pre-injury status  Other: Sitting at desk 8 hours  
Eval. Tx. Effectiveness Tools:  Revised Oswestry - Beginning Score \_\_\_\_\_ Goal Score \_\_\_\_\_  Neck Disability Index - Beginning Score 60% Goal Score 10%  
 Quad VAS - Beginning Score \_\_\_\_\_ Goal Score \_\_\_\_\_  Other: \_\_\_\_\_ Beginning Score \_\_\_\_\_ Goal Score or less

Signature of provider: [Signature] Date: 11/5/15

TREATMENT PLAN



Updated

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Patient's Name: Todd Patient Patient #: DCE 456  
Date this Episode Began: 11/5/15 Projected Completion of this Treatment Plan: 1/15/16

#1 Complaint:  C  T  L  Pelvis  Sac  Ext  Pain  Stiffness  Paresthesia  Spasms  Decreased ROM  Edema  Muscle Hypertonicity

Other: \_\_\_\_\_  
Patient complains of: Pain/stiff posterior neck

Functional Deficit Noted:  Personal Care  Lifting  Walking  Sitting  Standing  Work  Driving  Other: \_\_\_\_\_  
Inability to: Work at computer more than 50% of work day Diagnosis: Cervical Cranial Synd

Functional Treatment Goal: Able to work at computer full 8hr day by 1/15/16

#2 Complaint:  C  T  L  Pelvis  Sac  Ext  Pain  Stiffness  Paresthesia  Spasms  Decreased ROM  Edema  Muscle Hypertonicity

Other: \_\_\_\_\_  
Patient complains of: \_\_\_\_\_

Functional Deficit Noted:  Personal Care  Lifting  Walking  Sitting  Standing  Work  Driving  Other: \_\_\_\_\_  
Inability to: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Functional Treatment Goal: Able to \_\_\_\_\_ by \_\_\_\_\_

#3 Complaint:  C  T  L  Pelvis  Sac  Ext  Pain  Stiffness  Paresthesia  Spasms  Decreased ROM  Edema  Muscle Hypertonicity

Other: \_\_\_\_\_  
Patient complains of: \_\_\_\_\_

Functional Deficit Noted:  Personal Care  Lifting  Walking  Sitting  Standing  Work  Driving  Other: \_\_\_\_\_  
Inability to: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Functional Treatment Goal: Able to \_\_\_\_\_ by \_\_\_\_\_

Treatment Plan: Matching each complaint noted above : #1 #2 #3 #4 (including estimated number of units/visits i.e. for CMT it may be visits, but for TherEx it may be units)

Estimated # units this period				Estimated # units this period				Estimated # units this period			
<input checked="" type="checkbox"/> CMT <u>8</u> units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> U/S _____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Rehab 1 _____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Technique <u>DIV</u>				<input type="checkbox"/> Traction _____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Rehab 2 _____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<input type="checkbox"/> CMT-Ext _____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Man Therapy _____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Rehab 3 _____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<input type="checkbox"/> Hot+Cold _____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Massage _____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Other _____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<input type="checkbox"/> EMS _____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input checked="" type="checkbox"/> Thera Ex <u>6</u> units	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Other _____ units	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Frequency/Duration this period:  5 Visits X \_\_\_\_\_ Weeks  4 Visits X \_\_\_\_\_ Weeks  3 Visits X \_\_\_\_\_ Weeks  2 Visits X 4 Weeks  
 1 Visit X \_\_\_\_\_ Weeks  2 Visits X \_\_\_\_\_ Monthly  1 Visit X \_\_\_\_\_ Monthly

Complicating factors:  Obesity/Overweight  Diabetes  Other: none  
 Contraindications for Care: none

Home / Self Care Recommendations:  Ice  Moist Heat  Home Exercises per Instruction  Other: \_\_\_\_\_  
Other Recommendations:  C Pillow  L Pillow  Orthotics  Analgesic  Support/Brace \_\_\_\_\_  Rehab Equip \_\_\_\_\_  Nutrition \_\_\_\_\_  
 Add'l DX Testing \_\_\_\_\_  Other: \_\_\_\_\_

Long Term Goal:  Attain pre-condition/pre-injury status  Other: sitting @ desk w/o pain - 8 hrs

Eval. Tx. Effectiveness Tools:  Revised Oswestry - Beginning Score \_\_\_\_\_ Goal Score \_\_\_\_\_  Neck Disability Index - Beginning Score 40% Goal Score 10% or better  
 Quad VAS - Beginning Score \_\_\_\_\_ Goal Score \_\_\_\_\_  Other: \_\_\_\_\_ Beginning Score \_\_\_\_\_ Goal Score \_\_\_\_\_

Signature of provider: [Signature] Date: 12/7/15

TREATMENT PLAN