

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

First date of service: \_\_\_\_\_

- Diagnosis: 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

**Significant X-Ray Findings:**

Cervical: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Thoracic: \_\_\_\_\_

\_\_\_\_\_

Lumbar: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Contraindications/Precautions: \_\_\_\_\_

\_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Treatment Plan:

Doctor's Signature: \_\_\_\_\_

Date: \_\_\_\_\_