Name _____ Date _____ Type Case _____

Address _____ Phone _____

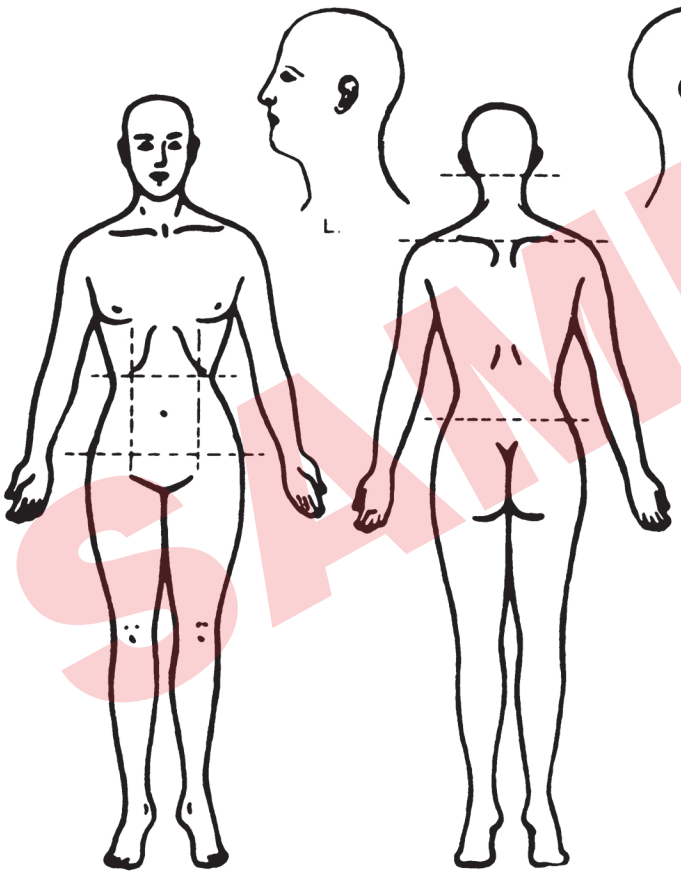
MAJOR SYMPTOMS: _____

DIAGNOSIS: _____

RE-EVALUATION REMARKS: _____

DISABILITY: From _____ To _____ Extended: _____

ESTIMATED TREATMENT LENGTH: _____



ORIGINAL L.	Seg.	ORIGINAL R.	RE-EVALUATION L.	Seg.	RE-EVALUATION R.
	Occ			Occ	
	C1			C1	
	2			2	
	3			3	
	4			4	
	5			5	
	6			6	
	7			7	
	D1			D1	
	2			2	
	3			3	
	4			4	
	5			5	
	6			6	
	7			7	
	8			8	
	9			9	
	10			10	
	11			11	
	12			12	
	L1			L1	
	2			2	
	3			3	
	4			4	
	5			5	
	Sac			Sac	
	Ril			Ril	
	Lil			Lil	
	Coc			Coc	
	Short Leg			Short Leg	
A – O%			A – O%		
C.ST%			C.ST%		
TH ST%			TH ST%		
L – S%			L – S%		
L. ST%			L. ST%		

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
JAN.																															
FEB.																															
MAR.																															
APR.																															
MAY																															
JUNE																															
JULY																															
AUG.																															
SEPT.																															
OCT.																															
NOV.																															
DEC.																															

X-RAY COMMENTS:

NUMBER	SERIES	DATE

#C-107

MISSION PRINTING (559) 227-7640 • (800) 693-2108

Name _____ Recommended Care _____

DATE	A	B	C	D	E	F	SUBJECTIVE - OBJECTIVE - ASSESSMENT - PLAN	PT. INIT.
10								
20								
30								
40								

DIET	☐	SUPPORT	☐	WEIGHT lbs.	A - CERVICAL ADJUSTMENT
VITAMINS	☐	C. PILLOW	☐	B.P.	B - THORACIC ADJUSTMENT
EXERCISE	☐	C. COLLAR	☐	PULSE /min.	C - LUMBAR ADJUSTMENT
FOOT LEVELERS	☐	URINALYSIS	☐	GRIP TEST: LT.	D - PELVIC ADJUSTMENT
HEEL LIFTS	☐	RELAXOBAK	☐	RT.	E - SACRAL
HEARTOMETER	☐			AGE	F - EXTRA SPINAL