

**SAMPLE -- PayDC Care Plan Quick-Form -- SAMPLE**

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

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Provider: \_\_\_\_\_

New Patient  Yes  No

**Diagnoses:**

<b>CERVICAL</b>	<b>Rank</b>	739.2 Thor Subluxation		846.0 Lumbosacral Strain/sp	
722.0 Disc Displac w/o mylop		839.21 Thor Dislocation		847.2 Lumbar Strain/sp	
722.4 Deg. of Intervtbral Disc		847.1 Thor Strain/Sprain		<b>SHOULDER</b>	<b>Rank</b>
723.1 Cervicalgia		<b>LUMBAR/SACRUM</b>	<b>Rank</b>	726.0 Adhes. Capsulitis Shld.	
723.4 Brachial Neuritis/Rad		720.2 Sacroiliitis NOS		726.10 Rotator Cuff Synd.	
723.5 Torticollis (unspec)		722.10 Lumbar IVD w/o mylop		<b>OTHER</b>	<b>Rank</b>
739.1 Cervical Subluxation		722.52 Deg. of Lumbar IVD		723.4 Brachial Neuritis/Radic	
839.0 ___Cerv Dislocation		724.2 Lumbago		728.71 Plantar Fasciitis	
847.0 Cervical Strain/Sprain		724.3 Sciatica		728.85 Muscle Spasm	
<b>THORACIC</b>	<b>Rank</b>	724.4 Lumbosacral Neur/Rad		729.1 Myalgia/Myositis Unsp.	
722.11 Thor IVD w/o mylop		739.3 Lumbar Subluxation		729.2 Neuralgia/Neuritis/Rad	
722.31 Schmorl's Nodes		739.4 Sacral Subluxation			
722.51 Thor Disc Degen		839.20 Lumbar Dislocation			
724.1 Thoracalgia		839.42 Sacral Dislocation			

Contributing Conditions:  Diabetes  Sciatica  Headaches  Arthritis  Stress  Sinus Prob  Pregnancy  Obesity

Other: \_\_\_\_\_

Aggravating Conditions:  Drives Truck  Heavy Lifting at work  Sits all day  Sports  Phone All Day  Computer work

Other: \_\_\_\_\_

Examination Level (e.g. 99021= level 1):  Level 1  Level 2  Level 3  Level 4  Level 5 Est. Re-exam Levels \_\_\_\_\_

Diagnostic Tests (list location): X-RAY \_\_\_\_\_ NCV \_\_\_\_\_ MRI \_\_\_\_\_

DX Test Rationale:  Radicular Symptoms  Rule out Pathology  Deformity/Immobility  Long Term Recurring pain

Other: \_\_\_\_\_

Long Term Goals:  Avoid Surgery  Elevate Core Strength  Restore Functional Independence  Restore Tolerance to ADL's

Enable to return to work  Reduce overall weight  Increase endurance  Increase Flexibility  Increase range of motion

Other: \_\_\_\_\_

Re-Evaluation performed: Every \_\_\_\_\_  visits  weeks  months Level: 1  2  3  4  5

**Choose Treatment Protocol (Indicate sites/treatment areas):**

<u>Plan Protocol</u> (Name from template)	<u>Rehab</u> (If not in Protocol)	<u>Rehab Goals</u>
<input type="checkbox"/> _____ C T L S P _____	<input type="checkbox"/> MFR TPT ART _____	(__ x / __ wks) _____
<input type="checkbox"/> _____ C T L S P _____	<input type="checkbox"/> Traction _____	(__ x / __ wks) _____
<input type="checkbox"/> _____ C T L S P _____	<input type="checkbox"/> Ther Ex _____	(__ x / __ wks) _____
<input type="checkbox"/> _____ C T L S P _____	<input type="checkbox"/> Home Ex _____	(__ x / __ wks) _____
<input type="checkbox"/> _____ C T L S P _____	<input type="checkbox"/> Other _____	(__ x / __ wks) _____
<input type="checkbox"/> _____ C T L S P _____	<input type="checkbox"/> Other _____	(__ x / __ wks) _____

**Extraspinal**

Shoulder  Elbow  Wrist  Thigh  Knee  Ankle  Foot  TMJ  Other \_\_\_\_\_ L R ( \_\_ x / \_\_ wks) \_\_\_\_\_