PLAN OF CARE

NAME: ___________________________ DATE: ___________ KV: ___________

PHASE: Acute/Sub-Acute/Chronic/Rehabilitative/Preventative RE-ASSESSMENT: 1 2 3 4 Weeks Other ______

INITIAL ASSESSMENT:

SHORT TERM GOALS: ___ 1 Week ___ 2 Weeks ___ 3 Weeks Other: __________________________

ADL ___________________________
HOME ___________________________
OBJECTIVE: ROM ___________________________
NEURO ___________________________

LONG TERM GOALS: ___ 1 Month ___ 2 Months ___ Other: __________________________

ADL ___________________________
HOME ___________________________
OBJECTIVE: ROM ___________________________
NEURO ___________________________

OUTCOME ASSESSMENTS INITIAL SCORE GOAL SCORE AT RE-ASSESSMENT
Revised Oswestry (Low Back) ____________ ____________
Neck Disability Index ____________ ____________
Headache Disability Index ____________ ____________
Lower Extremity Functional Scale ____________ ____________
Shoulder Pain and Disability Index ____________ ____________
Upper Extremity Functional Index ____________ ____________

COMPLICATING FACTORS: ___ Age; ___ DDD/DJD; ___ Radiating Symptoms; ___ Moderate/Severe Pain Level
___ Overweight; ___ Obese; ___ Poor Physical Condition; ___ Pain Present > 7 Days; ___ 3 or More Episodes of Similar Pain
___ Structural Abnormality as Indicated on Exam/Imaging; ___ Current Medications; ___ Hx of Trauma Related to Chief Complai
___ Organic/Systemic Complications Other __________________________

PROGNOSIS: Excellent / Good / Fair / Guarded / Poor Comments:

REstrictions: ___ Home ___ Work ___ Recreational ___ Leisure ___ Other __________________________

SPECIAL HOME CARE INSTRUCTIONS: ___ Ice ___ Heat ___ TENS ___ Traction ___ Exercise ___ Stretch
___ Support/Pillow ___ Per Instruction Sheet OTHER __________________________

Nutritional Support: Pain Inflammation Healing Neuro Joint GI Other __________________________

COMMENTS: __________________________

Signature ___________________________, DC Date: ___/___/____ Expiration Date: ___/___/____