American Specialty Health Plans of C... nia, Inc. (ASH Plans)
P.O. Box 509001, San Diego, CA 9215... 001
Fax 877/427-4777

CLINICAL TREATMENT FORM
(Chiropractic)

For question , please call ASH Plans at 800/972-4226

FOR ASH PLANS USE ONLY	ASH PLANS TREATMENT FORM #	RECEIVED DATE	ASH PLANS CLINICAL SERVICES MANAGER

Patient Name: Anderson, Tiffany (Last / First / Initial) Sex M / (F) Birthdate 8/22/70 Patient ID# C0078979694

☐ Work Related
Subscriber Name ____ Subscriber ID# ____ Is This? ☐ Auto Related

Health Plan: Kaiser Primary ☑ Secondary ☐ Employer ____ Group # C00000030305

	PATIENT MAILING ADDRESS AND PHONE NUMBER
Treating D C: Dr. James Gerard	Address: 1416 Iris dR #7
Address: 515 S. Fairmont #B	City/State/Zip: Lodi Ca. 95242
City/State/Zip: Lodi, Ca. 95240	Phone (209) 333-1032
Phone (209) 333-2401 Fax (209) 333-9202	

DATES OF SERVICES RENDERED UNDER THE TREATMENT FORM WAIVER: (Required) ☐ No services rendered

Exam/1st OV date (mm/dd/yyyy) current benefit year ____ Response to care ____
Last OV date under TFW 9/13/06
Total # of OVs rendered under TFW 5
X-rays/Supports (CPT Codes) ____

ICD-9 CODES / DIAGNOSES (must be to the highest level of specificity):
1 7292 Cervical Radiculitis 3 ____
2 ____ 4 ____

TREATMENT/SERVICES SUBMITTING FOR REVIEW.

From 3/21/06 Through 5-21-07
Estimated Date of Release (Required) ____
Exam (performed within above dates): ☐ New ☒ Established
Date of Exam Findings. (mm/dd/yyyy) 3/21/06
Adj /Manip (Type) MSR, Cox
Therapy (Type) STim
Supports/Appliances ____
X-ray Views (performed within above dates) ____

	# Office Visits	# Therapies
0 - 15 days	4	4
16 - 30 days		
31 - 45 days		
46 - 60 days		
TOTAL	4	4

IMAGING STUDIES Date taken ____ Views ____ ☐ Taken at outside facility
Findings ____
Rationale for films ____

CHIEF COMPLAINTS 1 neck pain 2 rad to both suprascaps 3 ____ 4 ____
DATE OF ONSET (mm/dd/yyyy) 3-20-07
MECH OF INJURY/EXACERBATION Overexertion, lifting
PERTINENT PAST HISTORY Chronic neck

VITAL SIGNS Height 5'13½ Weight 143 Blood Pressure 87/68 Temp ____

ROM: Cervical spine ☐ N/A ☐ All WNL **Flexion** 50/60 or ___% limited **Extension** 25/50 or ___% limited
Lat flex Left 33/40 or ___% limited Right 30/40 or ___% limited **Rotation Left** 70/80 or ___% limited Right 65/80 or ___% limited
Lumbosacral spine ☐ N/A ☐ All WNL **Flexion** ___/90 or ___% limited **Extension** ___/30 or ___% limited
Lat flex Left ___/20 or ___% limited Right ___/20 or ___% limited **Rotation Left** ___/30 or ___% limited Right ___/30 or ___% limited
Other ____

ORTHO/NEURO/VASCULAR/VBI ☐ N/A ☐ All WNL (Please include location and intensity of findings)
Foram comp (+5) to both scaps
bilat shoulder dep

CHIROPRACTIC/PALPATORY ASSESSMENT: tenderness bilat C-T

FUNCTIONAL ASSESSMENT/IMPROVEMENT: ____

EXERCISE/HOME CARE ____
OUTCOME ASSESSMENTS. ☐ N/A Date score obtained ____ ☐ Neck Disability score ____ ☐ Roland-Morris score ____
☐ Oswestry Low Back score ____ ☐ Perceived Improvement ____ % ☐ Other (name) score ____
ADD'L COMMENTS ____

Signature of treating D C (Required) [signature] Date 4-25-07

02/01/2006

...CTF 11/2/05 ...