American Specialty Health Plans of C rnia, Inc. (ASH Plans)
P.O. Box 509001, San Diego, CA 92150-9001
Fax: 877/427-4777

C VICAL TREATMENT FORM
(Chiropractic)

For questions, 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 (mm/dd/yyyy) Patient ID# CDD789 7969.

Subscriber Name: _____ Subscriber ID#: _____ ☐ Work Related Is This? ☐ Auto Related

Health Plan: Kaiser Primary ☑ Secondary ☐ Employer: _____ Group #: CDDDDD030305

Treating D.C.: Dr. James Gerard
Address: 515 S. Fairmont #B.
City/State/Zip: Lodi, Ca. 95240
Phone: (209) 333-2401 Fax: (209) 333-9202.

PATIENT MAILING ADDRESS AND PHONE NUMBER
Address: 1416 Iris dr #7
City/State/Zip: Lodi Ca. 95242
Phone: (209) 339-1032

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. 729.2 Cervical Radiculitis 3. _____
2. _____ 4. _____

TREATMENT/SERVICES SUBMITTING FOR REVIEW:

From: 3/21/06. Through: 5-21-07

	# Office Visits	# Therapies
Estimated Date of Release: (Required) _____ 0 - 15 days	4	4
Exam (performed within above dates): ☐ New ☒ Established 16 - 30 days		
Date of Exam Findings: (mm/dd/yyyy) 3/21/06 31 - 45 days		
Adj./Manip.: (Type) MET, Cox 46 - 60 days		
Therapy: (Type) Stim		
Supports/Appliances: TOTAL	4	4
X-ray Views (performed within above dates):		

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

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

VITAL SIGNS: Height 5'3½ 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 39/40 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.) _____
Foramen comp (+) b both scaps
bilat shoulder dep
CHIROPRACTIC/PALPATORY ASSESSMENT: tenders 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): _____ Date: 4-25-07