

# Medical Associates Health Plans Chiropractic Treatment Plan

Patient's first Name:	Patient's Last Name:	ID#:
DOB (mm/dd/yyyy):	Diagnosis:	
Mode of Onset: <input type="checkbox"/> Accident <input type="checkbox"/> Illness	<input type="checkbox"/> Injury <input type="checkbox"/> Work Related	<input type="checkbox"/> Other
Date of Onset (mm/dd/yyyy):		
Episode of Care (mm/dd/yyyy):		
Examination findings at the initial visit and most recent reevaluation:		
Diagnostic testing, imaging results, complicating factors:		
Treatment provided including home care and coordination with other specialists:		
Goals/objectives, prognosis and rationale for additional care:		
Requested Care:		
Anticipated Frequency and Duration:		
Anticipated Dates of Care:	<i>From (mm/dd/yyyy)</i>	<i>To (mm/dd/yyyy)</i>
<i>Provider Signature:</i>		
<i>Return Address:</i>		
<i>Telephone #:</i> ( )	<i>Fax #:</i> ( )	<i>Email Address:</i>



**MEDICAL ASSOCIATES**  
HEALTH PLANS®

1605 Associates Drive, Suite 101 ♦ Dubuque, Iowa 52004-5002  
(563) 556-8070 or (800) 747-8900