Chiropractic Treatment Plan

PATIENT INFORMATION

Name: _____ Date of birth: _____ dd / mm / yyyy

Gender: _____ Date of assessment: _____ dd / mm / yyyy

Contact information:

Medical history:

COMPREHENSIVE ASSESSMENT

Presenting complaint(s):

Lifestyle factors (e.g., occupation, activity level, stress):

Assessment methods used:

- [ ] Physical examination
- [ ] Orthopedic/neurological testing
- [ ] Imaging (X-ray or MRI)
- [ ] Range of motion assessment
- [ ] Postural evaluation
- [ ] Other

Findings and diagnosis:

I. PRIMARY GOALS

Select all that apply:

- [ ] Pain reduction
- [ ] Improve mobility
- [ ] Restore function
- [ ] Prevent recurrence
- [ ] Other

Specify range: _____

II. SHORT-TERM GOALS

Specify below:

Specify range: _____

III. LONG-TERM GOALS

Specify below:

Specify range: _____ **Expected frequency of visits:** _____

IV. TECHNIQUES USED

Select all that apply:

- [ ] Spinal adjustments
- [ ] Manual therapy
- [ ] Therapeutic exercises
- [ ] Soft tissue techniques
- [ ] Lifestyle modification
- [ ] Other

SPINAL ADJUSTMENTS

I. Areas of focus:

- [ ] Cervical
- [ ] Thoracic
- [ ] Lumbar
- [ ] Sacral/pelvic

II. Adjustment techniques:

- [ ] Diversified
- [ ] Gonstead
- [ ] Activator method
- [ ] Thompson drop
- [ ] Other

THERAPEUTIC EXERCISES

I. Exercise objectives:

- [ ] Muscle strengthening
- [ ] Flexibility improvement
- [ ] Posture correction
- [ ] Balance training

II. Prescribed exercises (include reps/sets/frequency):

LIFESTYLE GUIDANCE

I. Education topics covered:

- [ ] Posture and ergonomics
- [ ] Home/workplace modifications
- [ ] Nutrition and anti-inflammatory diet
- [ ] Stress management techniques
- [ ] Sleep hygiene

II. Patient resources:

- [ ] Handouts
- [ ] Exercise sheets
- [ ] Referral to specialist
- [ ] Online portal access

FOLLOW-UP AND RE-EVALUATION PLAN

Select one:

- ◯ Weekly progress reviews
- ◯ Monthly re-assessment
- ◯ Patient self-reporting logs
- ◯ Functional outcome measures

Next review date: _____ dd / mm / yyyy

Practitioner notes/comments:

ADDITIONAL NOTES

Specify below:

HEALTHCARE PROFESSIONAL INFORMATION

Name: _____ **License ID number:** _____

Signature: