

Conservative Treatment History Form (Advanced Imaging)

Conservative treatment provides significant clinical value to patients who may truly benefit from advanced imaging. As such, proper documentation of recent efforts at conservative care is crucial to establishing the need for further testing and/or treatment.

IMPORTANT: Please type or print CLEARLY. Once completed and attested, upload this document via RadMD. Processing may be delayed if information submitted is illegible or incomplete.

Today's Date: Tracking Number:	Patient Name: Date of Birth:
Clinical Questions:	
Has the patient had these symptoms for six months or more?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If no to the above, how long has the patient had these symptoms?	
Conservative treatments tried for the problem:	
Any recent activity modification, rest or bracing?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Any recent trial of medications and/or injections?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Any recent physical therapy?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes to <i>physical therapy</i> , please complete this section.	
Physical therapy start date: _____ Date of last session: _____	
Type(s) of exercises/modalities: _____	
Number of sessions completed: _____	
How did the patient feel after/during the therapy intervention? <input type="checkbox"/> BETTER <input type="checkbox"/> SAME <input type="checkbox"/> WORSE	
Any recent physician-directed home exercise program (HEP)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes to <i>physician-directed home exercise program</i> , please complete this section.	
Name of supervising Physician ordering the exercise program: _____	
Type of exercises: _____	
Date when the exercise plan and instructions were given to the patient: _____	
Date when patient started home exercise program: _____ Date of last session: _____	
Frequency and duration of the exercises performed (how many times per week and for how long) _____	
Date of in-office physician reassessment completed after the prescribed home exercise program: _____	
How did the patient feel after/during the home exercises? <input type="checkbox"/> BETTER <input type="checkbox"/> SAME <input type="checkbox"/> WORSE	
PLEASE SUBMIT A COPY OF THE HOME EXERCISE PROGRAM WITH THIS DOCUMENT	

Any recent chiropractic care?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<p>If yes to <i>chiropractic care</i>, please complete this section.</p> <p>Chiropractic treatment start date: _____ Date of last session: _____</p> <p>Number of sessions completed: _____</p> <p>How did the patient feel after/during the treatment? <input type="checkbox"/> BETTER <input type="checkbox"/> SAME <input type="checkbox"/> WORSE</p>	
Select the spinal area for which the conservative care has been completed:	<input type="checkbox"/> CERVICAL (NECK) <input type="checkbox"/> THORACIC (MID BACK) <input type="checkbox"/> LUMBAR (LOW BACK)
Select the joint for which the conservative care has been completed:	<input type="checkbox"/> JAW <input type="checkbox"/> SHOULDER <input type="checkbox"/> ELBOW <input type="checkbox"/> WRIST <input type="checkbox"/> HAND <input type="checkbox"/> HIP <input type="checkbox"/> PELVIS (SACRO-ILIAC) <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> OTHER
<p>By making this submission, I attest, either as the ordering provider or as authorized by the ordering provider, that all statements made herein are true and verified by specific documentation in the medical record of the applicable patient, and I/the ordering provider understand(s) that misrepresentations made in this submission may be investigated for fraud, and/or abuse.</p> <p>I attest that standard initial clinical workup (physical examination, laboratory testing, and review of prior abnormal imaging reports) has been completed and treatment has failed to improve the patient's clinical condition.</p> <p><input type="checkbox"/> I ATTEST <input type="checkbox"/> I DO NOT ATTEST</p>	
<p>Signatures</p> <p>This completed, signed form will be part of the patient's medical record. When <u>history</u> of conservative treatment is required, this form or all information requested herein should be supplied.</p>	
<p>_____</p> <p>Provider Signature (Please Print and Sign)</p>	