DC Short Form

**Thank you for your support.**
Please complete this form on all consecutive patients throughout your participation, no exceptions (even if the patient decides not to complete their form or is non-English speaking).

**Patient Data (Note - ALL patients are eligible, regardless of age):**

**1)** Age ________ months / years *(circle one)* **2)** Gender ☐ Male ☐ Female
**3)** Presenting Condition(s): ☐ Preventative/Wellness/No Symptoms ☐ Headache ☐ Neck Pain ☐ Thoracic Back Pain ☐ Low Back Pain ☐ Extremity pain ☐ Other, specify ________
**4)** Radicular Pain? ☐ Yes ☐ No **5)** Please indicate if the primary condition is: ☐ Chronic ☐ Acute
**6)** Any manual therapy within the last week? ☐ Yes ☐ No
**7)** How long has this patient been receiving manual therapy? ________ months / years *(circle one)*

**Treatment** ***(please indicate which type of manual therapy and how often applied done for each anatomic location)***

| | Cervical Spine | Thoracic Spine | Lumbar Spine | Sacrum / Pelvis | Upper Extremity | Lower Extremity | Other* |
|---|---|---|---|---|---|---|---|
| **# of Manipulations** | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ |
| **# of Mobilizations** | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ |
| **Mechanical Device** | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ |
| **Other Manual Tx*** | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ |
| **Other Non-Man. Tx*** | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ | ☐1 ☐2 ☐3+ |

***Other *(specify)*** ____________________

**Adverse Event**
Was there any adverse event after the manual therapy treatment? ☐ No ☐ Yes *(complete table below)*

| **Adverse Event** ***(check all that apply)*** | **Location** ***(if applicable)*** | **Anticipated** | **Overall Severity Rating** |
|---|---|---|---|
| ☐ Discomfort/Pain | | ☐ Yes ☐ No | ☐ Mild ☐ Moderate ☐ Severe ☐ Serious |
| ☐ Stiffness | | ☐ Yes ☐ No | ☐ Mild ☐ Moderate ☐ Severe ☐ Serious |
| ☐ Weakness | | ☐ Yes ☐ No | ☐ Mild ☐ Moderate ☐ Severe ☐ Serious |
| ☐ Fatigue/Tiredness | | ☐ Yes ☐ No | ☐ Mild ☐ Moderate ☐ Severe ☐ Serious |
| ☐ Headache | | ☐ Yes ☐ No | ☐ Mild ☐ Moderate ☐ Severe ☐ Serious |
| ☐ Dizziness | | ☐ Yes ☐ No | ☐ Mild ☐ Moderate ☐ Severe ☐ Serious |
| ☐ Difficulty with vision | | ☐ Yes ☐ No | ☐ Mild ☐ Moderate ☐ Severe ☐ Serious |
| ☐ Sleeping Disturbances | | ☐ Yes ☐ No | ☐ Mild ☐ Moderate ☐ Severe ☐ Serious |
| ☐ Irritability / Crying | | ☐ Yes ☐ No | ☐ Mild ☐ Moderate ☐ Severe ☐ Serious |
| ☐ Dysarthria | | ☐ Yes ☐ No | ☐ Mild ☐ Moderate ☐ Severe ☐ Serious |
| ☐ Nausea/Vomiting | | ☐ Yes ☐ No | ☐ Mild ☐ Moderate ☐ Severe ☐ Serious |
| ☐ Numbness/Tingling | | ☐ Yes ☐ No | ☐ Mild ☐ Moderate ☐ Severe ☐ Serious |
| ☐ Strains/Sprains | | ☐ Yes ☐ No | ☐ Mild ☐ Moderate ☐ Severe ☐ Serious |
| ☐ Gait Disturbances | | ☐ Yes ☐ No | ☐ Mild ☐ Moderate ☐ Severe ☐ Serious |
| ☐ Other: __________ | | ☐ Yes ☐ No | ☐ Mild ☐ Moderate ☐ Severe ☐ Serious |



Appointment Date: __ __ / __ __ / 201__ Visit Code

Visit Number: ________