

Treatment Status - Helene Price

CLIENT NAME:

DATE OF ACCIDENT: ____ / ____ / ____

DATE:

FILE NO.: _____

NAME, ADDRESS AND TELEPHONE NUMBER OF DOCTOR YOU ARE CURRENTLY TREATING WITH:

HOW OFTEN ARE YOU RECEIVING PHYSICAL THERAPY?

ARE YOU TREATING WITH ANY SPECIALIST?

IF SO, LIST NAME, ADDRESS AND TELEPHONE NUMBER OF SPECIALIST:

PRESENT COMPLAINTS:

DO YOU HAVE ANY TINGLING, NUMBNESS OR FALLING ASLEEP SENSATIONS IN YOUR ARMS OR LEGS?

ARE YOU SATISFIED WITH THE TREATMENT YOU ARE RECEIVING FROM YOUR DOCTOR?

HAVE YOU COMPLETED YOUR TREATMENT?

IF SO, WHEN WERE YOU FORMALLY DISCHARGED?

DID YOU MISS TIME FROM WORK?

IF SO, LIST DATES YOU MISSED FROM WORK



X



Signature Certificate

Document name: Treatment Status - Helene Price

🔒 Unique Document ID: E41CE48FFFBFA0F837C86B26F16643E01E0E7708

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Timestamp

May 20, 2020 7:21 pm GMT

May 20, 2020 11:57 pm GMT

Audit

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This audit trail report provides a detailed record of the online activity and events recorded for this contract.

Page 3 of 3