

Alpha Prefix Member ID Number

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* **Note:** The above Member ID number **MUST** be identical to the Member ID number provided on Page 1 of this form.)

REQUEST INFORMATION

Condition Type: ☐ Acute (less than 2 months) ☐ Sub-acute (2-3 months) ☐ Chronic (more than 3 months)

Primary Diagnosis Code

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 (ICD-10 Format)

Affected Region: ☐ Right ☐ Left ☐ Bilateral ☐ Not Applicable

Onset: ☐ Insidious/No Trauma ☐ Traumatic Injury ☐ Repetitive Stress ☐ Post-Operative
☐ Work-related ☐ Motor Vehicle

For Post-Operative Cases Only:

Type of Surgery: ☐ Joint Replacement ☐ ACL Reconstruction ☐ Rotator Cuff/Labral Repair ☐ Spinal Fusion
☐ Arthroscopy ☐ Tendon Repair ☐ Other: _____

Date of Surgery

		/			/				
Month			Day			Year			

Chief Complaint(s):

- ☐ Pain ☐ Stiffness ☐ Weakness
☐ Loss of Balance ☐ Decreased/Loss of Function
☐ Other: _____

Frequency of Symptoms:

- ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

Impact of Symptoms on ADL:

- ☐ None ☐ Minimal ☐ Moderate ☐ Significant

Pain Intensity (0-10):

Last 24 hours		Past Week	

Muscle Strength (MMT): ☐ 5/5 ☐ 4/5 ☐ 4-/5 ☐ 3+/5 ☐ 3/5 ☐ 3-/5 ☐ 2+/5 ☐ 2/5 ☐ 1/5 ☐ 0/5

Active Range of Motion Limitations: ☐ None ☐ Minimal ☐ Moderate ☐ Significant

Functional Limitations: ☐ None ☐ Minimal ☐ Moderate ☐ Significant

**Functional Measure Score
(For Chief Complaint):**

Most Recent Score		

Form Type: ☐ Neck ☐ Back ☐ SF 12/36
☐ LEFS ☐ DASH ☐ KSS
☐ Other: _____

Progress since first visit: ☐ None, first visit ☐ No Progress Yet ☐ Some Progress ☐ Significant Progress
☐ Significantly Worse