

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

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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):

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Last 24 hours

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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):**

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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

