# 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:<br>Tracking Number: | Patient Name:<br>Date of Birth: |
| **Clinical Questions:** | |
| Has the patient had these symptoms for six months or more? | ☐ **YES** ☐ **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?** | ☐ **YES** ☐ **NO** |
| **Any recent trial of medications and/or injections?** | ☐ **YES** ☐ **NO** |
| **Any recent physical therapy?** | ☐ **YES** ☐ **NO** |

If yes to *physical therapy*, 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? ☐ **BETTER** ☐ **SAME** ☐ **WORSE**

| | |
|---|---|
| **Any recent physician-directed home exercise program (HEP)?** | ☐ **YES** ☐ **NO** |

If yes to *physician-directed home exercise program*, 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? ☐ **BETTER** ☐ **SAME** ☐ **WORSE**

**PLEASE SUBMIT A COPY OF THE HOME EXERCISE PROGRAM WITH THIS DOCUMENT**

| | |
|---|---|
| **Any recent chiropractic care?** | ☐ **YES** ☐ **NO** |
| If yes to *chiropractic care*, please complete this section.<br><br>Chiropractic treatment start date: _____ Date of last session: _____<br><br>Number of sessions completed: _____<br><br>How did the patient feel after/during the treatment? ☐ **BETTER** ☐ **SAME** ☐ **WORSE** | |
| **Select the spinal area for which the conservative care has been completed:** | ☐ **CERVICAL (NECK)** ☐ **THORACIC (MID BACK)** ☐ **LUMBAR (LOW BACK)** |
| **Select the joint for which the conservative care has been completed:** | ☐ **JAW** ☐ **SHOULDER** ☐ **ELBOW** ☐ **WRIST** ☐ **HAND** ☐ **HIP** ☐ **PELVIS (SACRO-ILIAC)** ☐ **KNEE** ☐ **ANKLE** ☐ **FOOT** ☐ **OTHER** |
| 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.<br><br>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.<br>☐ I ATTEST ☐ I DO NOT ATTEST | |
| Signatures<br>This completed, signed form will be part of the patient's medical record. When history of conservative treatment is required, this form or all information requested herein should be supplied. | |
| _____<br>Provider Signature (Please Print and Sign) | |