Bryant Chiropractic and Massage

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Determination of Urgency and Medical Necessity of Massage For Acute Pain Control, Severe Whiplash and Lymphatic Overwhelm

Patient Name: _____ Date:_____

Date of Birth: _____ Insurance Name:_____ ID #_____

1. When did your condition/pain start? **Onset Date:** _____ **Cause:**_____
2. Are you experiencing Lymphatic Overwhelm (Severe Swelling)? ☐ Yes ☐ No **Cause:**_____
3. Is your condition causing you significant pain? ☐ Yes ☐ No
4. Is your condition causing you a continuation or worsening of significant or severe pain? ☐ Yes ☐ No
5. Without therapy, would your condition require medications to manage your pain? ☐ Yes ☐ No
6. Is your condition causing you significant dysfunction in your daily life or work? ☐ Yes ☐ No
7. Is your condition getting progressively worse? ☐ Yes ☐ No
8. Where is your pain located and how much is your pain on a 0 to 10 pain scale? Please, check below.
9. How often is your pain? Please, check what applies in the form bellow.
10. What activities make it worse? Please, write down the activity and how long you can perform it, before your pain gets worse? (Example: sitting > 10 min.)

Examples of ADLs: **sitting, standing, walking, bending, lifting, stair climbing, working, personal care, driving, sleeping, child care, house cleaning, etc.**

Headaches/ Migraines:

Pain Level (0-10 scale): Worst Pain_____

Pain Frequency (Please, check what applies):

Constant (75% to 100% of waking hours) ___ Frequent (50% to 75% of waking hours) _____

Occasional (25% to 50% of waking hours) ___ Intermittent (less than 25% of waking hours)_____

Aggravating Activities: _____

Neck Pain:

Pain Level (0-10 scale): Worst Pain_____

Pain Frequency (Please, check what applies):

Constant (75% to 100% of waking hours) ___ Frequent (50% to 75% of waking hours) _____

Occasional (25% to 50% of waking hours) ___ Intermittent (less than 25% of waking hours)_____

Aggravating Activities: _____

Upper Back Pain:

Pain Level (0-10 scale): Worst Pain_____

Pain Frequency (Please, check what applies):

Constant (75% to 100% of waking hours) ___ Frequent (50% to 75% of waking hours) _____

Occasional (25% to 50% of waking hours) ___ Intermittent (less than 25% of waking hours)_____

Aggravating Activities: _____

Low Back Pain

Pain Level (0-10 scale): Worst Pain_____

Pain Frequency (Please, check what applies):

Constant (75% to 100% of waking hours) ___ Frequent (50% to 75% of waking hours) _____

Occasional (25% to 50% of waking hours) ___ Intermittent (less than 25% of waking hours)_____

Aggravating Activities: _____

Other Area: _____

Pain Level (0-10 scale): Worst Pain_____

Pain Frequency (Please, check what applies):

Constant (75% to 100% of waking hours) ___ Frequent (50% to 75% of waking hours) _____

Occasional (25% to 50% of waking hours) ___ Intermittent (less than 25% of waking hours)_____

Aggravating Activities: _____

Other Area: _____

Pain Level (0-10 scale): Worst Pain_____

Pain Frequency (Please, check what applies):

Constant (75% to 100% of waking hours) ___ Frequent (50% to 75% of waking hours) _____

Occasional (25% to 50% of waking hours) ___ Intermittent (less than 25% of waking hours)_____

Aggravating Activities: _____

Patient Name: _____ **Date:**_____

Patient Signature:_____