NORTHWEST BRAIN & SPINE

CONSERVATIVE THERAPY UPDATE:

Patient Name:_____ Date: _____

Have you had any of the following in the past 6 months? If so, please indicate where, when, and contact information for facility.

Physical Therapy: (circle) Y or N

_____

Occupational Therapy: (circle) Y or N

_____

Massage Therapy: (circle) Y or N

_____

Chiropractic Treatments: (circle) Y or N

_____

Acupuncture Treatments: (circle) Y or N

_____

Injections: (circle) Y or N

_____

New Xrays, CT scan, MRI outside of the Central Oregon Area: (circle) Y or N

_____

Is there anything else your provider needs to know for this visit?

_____

_____

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