Clinician Name	Date of Service
Phone	Address

First Name: _____

Last Name: _____

First time at this clinic: Yes No

Date of Birth: _____

Who/Where referred:

_____

Why I am here today:

_____

_____

_____

Previously diagnosed Chronic Conditions and date of diagnosis:

_____

_____

_____

_____

Medications and supplements that I took since last visit overview (name, dosage, and start-end date):

_____

_____

_____

_____

_____

Some notable events that happened since my last appointment:

_____

_____

_____

Issues that I have been having:

Issue #1	
Start Date:	
Location	
Duration	
Severity	
Comments:	

Issue #2	
Start Date:	
Location	
Duration	
Severity	
Comments:	

Issue #3	
Start Date:	
Location	
Duration	
Severity	
Comments:	

Issue #4	
Start Date:	
Location	
Duration	
Severity	
Comments:	

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Clinician Name	Date of Service
Phone	Address

Diagnosis: _____ **ICD:** _____ **Date:** _____

Diagnosis: _____ **ICD:** _____ **Date:** _____

Treatment Plan Overview: (Option(s), calculator, start treatment date(s), duration)

_____

_____

_____

_____

_____

Follow-up: (Wait for clearance, follow treatment plan, contribute to outcome)

_____

_____

_____

_____

_____

Clinic Support Staff: _____

_____

_____

Outcome Overview, shared outcome, & Date:

Additional Notes: _____

_____

_____

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