Chiropractic Care Schedule

820 NE Northgate Way | Seattle, WA 98125
Phone (206) 440-7700

Patient Name: ______________________________

I. CARE OBJECTIVE AND FREQENCY

1. Relief	week / month for	days / weeks / months
2. Correction	week / month for	days / weeks / months
3. Strengthening	week / month for	days / weeks / months
4. Maintenance	week / month for	days / weeks / months

II. THERAPY & EDUCATION

☐ Heat	☐ Flexion/Distraction	☐ PNF
☐ Cryotherapy	☐ Manual Traction	☐ Leander
☐ Intersegmental traction	☐ Muscle Goading	☐ Exercises
☐ 2 weeks	☐ 4 weeks	☐ 6 weeks

☐ New Patient Orientation Class ______________________________

Day Date Time

III. CASE RE-EVALUATION

Re-examination(s) after:	weeks / treatment
Re-x-rays after:	weeks / treatment
Re-evaluation after:	weeks / treatment

IV. YOUR CARE SUMMARY

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I understand my chiropractic care program and that the success of this program is dependent on keeping my appointments, following my doctor's instructions and communicating with my doctor about my case, care and treatment.

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Patient's Signature Date Doctor's Signature Date