



Level One Case Report Form

Patient Name: _____ Handedness: _____ Date: _____ Visit #: _____

A: COMPLAINTS: (Include measures for complaints; i.e. 0-10 scale for pain, 10 being most extreme, % limitation for Range of Motion, 0 – 10 scale for satisfaction with sleep, energy, mood, 10 being best possible).	Check One:		<u>Ptfinder Scale</u>	<u>Treated?</u>
	Right	Left		
List considered points below:				
1.				
2.				
3.				
4.				
B: FUNCTIONAL SUPPORT POINTS. NOTE: If not listed as a complaint, INCLUDE sleep, energy, mood here.				



C. HISTORY: Scars; Chronic Inflammations (include dental) or Other Chronic Conditions:	Check One		<u>Chronology</u> Year or Age	<u>Ptfinder</u> Scale	<u>Treated</u> ?
	Right	Left			
1.					
2.					
3.					
4.					
5.					
6.					

POST TREATMENT ASSESSMENT (Include patient comments, pain and range of motion, change in other measures, clinical observations, direction):

Clinician: _____