Conservative Treatment Form

Your Insurance Company requires us to have this information in your record to be able to get any Radiology testing such as MRI, CT, MRA's approved.

Please list **ANY** and **ALL** conservative treatment you have had for the condition you are being seen for today. This should include treatment prescribed by **ANY** of your physicians.

Circle any treatment/medications that are listed below that apply and for each one you have circled, we need to know about how long you have been doing the treatment or taking the medications.

This information is required for insurance purposes, if you are a surgery candidate.

Physical Therapy	_____	days	_____	weeks	_____	months	_____	years
Steroid Injections	_____	days	_____	weeks	_____	months	_____	years
Muscle relaxers	_____	days	_____	weeks	_____	months	_____	years
Pain medications	_____	days	_____	weeks	_____	months	_____	years
Ibuprofen/Motrin	_____	days	_____	weeks	_____	months	_____	years
Back/Neck braces	_____	days	_____	weeks	_____	months	_____	years
Pain Management	_____	days	_____	weeks	_____	months	_____	years

If you have had any other treatment please list it below with how long you have been doing the treatment/medication.

_____

_____

_____

_____

_____

Signature: _____ Date: _____