NORTHWESTERN HEALTH SCIENCES UNIVERSITY

Patient Treatment Plan & Goals –Reviewed every 8 Treatment Sessions

Patient Information			
Date:		**Pt Name:**	
D/O/B:		**Sex:**	☐ **Male** ☐ **Female**

Medications:	
1.	3.
2.	4.

Problem/Concern List: (list date completed – transfer incompletes to new form)	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Unique Patient Information. Why? (re: language, contagious illnesses, artificial limb/joints, pacemaker, etc)

Initial Diagnosis or Diagnoses: (MUST BE FILLED IN)

Overall Plan of Case Management (to be re-evaluated every 8 sessions)

Key: AC=Acupuncture; CH=Chiropractic; NP=Nurse Practitioner; MD=Medical; MT=Massage Therapy; PS=Psychology

Signatures of IHC Interns & Supervisor

IHC Intern/Discipline	Date	Supervisor