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MNR FORM – Acupuncture - Page 1

For questions, please call ASH at 800.972.4226

FOR ASH USE ONLY	ASH MNR FORM #	RECEIVED DATE	ASH CLINICAL QUALITY EVALUATION MANAGER

Patient Name__________ (Last / First / Initial) Sex M / F Birthdate___ / ___ / _____ (mm / dd / yyyy) Patient ID # __________

Subscriber Name__________ Subscriber ID #__________ Employer__________

Health Plan__________ ☐Primary ☐Secondary Group #__________ Is this? ☐Work Related? ☐Auto Related?

PCP Name__________ Phone #__________

	PATIENT MAILING ADDRESS AND PHONE NUMBER
Clinic Name__________	
Treating Practitioner__________	
Address__________	Address__________
City/State/Zip__________	City/State/Zip__________
Phone (_____)_______ Fax (_____)	Phone (_____)

CONDITION TREATED, DIAGNOSIS AND ICD-9 CODE

1__________ ______
2__________ ______
3__________ ______
4__________ ______

☐ Acute Condition ☐ Chronic Condition ☐ Continuing Care
☐ Co-managed Care ☐ Supportive Care

Eastern Diagnoses:
__________ __________

TREATMENT/SERVICES SUBMITTING FOR REVIEW

Date: From ___ / ___ / _____ Through ___ / ___ / _____
Total # Office Visits/Acupuncture__________
☐ Established Patient Exam Date__________
Estimated Date of Release_____ / _____ / _____

☐ Acupuncture ☐ Electro-stimulation ☐ Acupressure/Tui-Na ☐ Home Care Advice
☐ Diet ☐ Cupping ☐ Cold/Heat Pad ☐ GuaSha ☐ Herbs ☐ Infrared/Heat Lamp
☐ Moxibustion ☐ Rehab Exercise ☐ Nutritional Supplements__________
☐ Other__________

Treatment Goal:

Services provided prior to today and the treatment outcome:

Total # of Treatments _____ performed. Patient's response to care__________

Pain has ☐ Decreased ☐ No Change ☐ Worsened ☐ Decreased only for a short period of time__________

Functional Ability Change ☐ Improving ☐ No Change ☐ Getting Worse. Explain:__________

Current main complaint(s) __________

Mechanism of injury/date of onset ☐ Traumatic ☐ Repetitive ☐ Exacerbation ☐ Recurrent / Chronic ☐ Unknown ☐ Post-Surgical ______

Pertinent health history __________

Other ongoing treatments (e.g., medications, therapies)__________

Height_______, **Weight** _______lb, **BP**_____ / _____ mmHg, **Temperature** ________, **Pulse** ______

Summary of your examination findings (or attach page 2): Date of exam ____ / ____ / _____ **Findings**: __________

Activities of Daily Living are ☐normal ☐ mildly affected ☐ severely affected: __________

Observation__________

Palpation__________

Range of Motion__________

Orthopedic Testing__________

Neurological Assessment__________

Tongue Signs__________, **Pulse Signs R:** __________ **L:** __________

Additional Clinical Findings__________

PLEASE SUBMIT THIS FORM WITH INITIAL HEALTH STATUS (INITIAL CARE) OR PATIENT PROGRESS FORM (ONGOING CARE)

Signature of treating acupuncture practitioner__________ **Date**__________

Acupuncture Clinical Findings

Patient Name________________________ Occupation_________________ Practitioner Name___________________________

Pain Descriptions:

Pain Condition #1: Location ________________ Intensity (1-10) _____ Frequency_______________ Duration________ hours/days

Pain is ☐Sharp ☐Dull ☐Stabbing ☐Burning ☐Spasmodic ☐Tingling ☐Throbbing ☐Stiffness ☐Distension or ___________

Aggravating factors:_________________________________ Alleviating factors:____

Pain Condition #2: Location _______________ Intensity (1-10) _____ Frequency ___________________ Duration_______hours/days

Pain is ☐Sharp ☐Dull ☐Stabbing ☐Burning ☐Spasmodic ☐Tingling ☐Throbbing ☐Stiffness ☐Distension or ___________

Aggravating Factors:____________________________________ Alleviating Factors:____________________________________

Other Pain Conditions:____

Clinical Findings Related to Pain Location:

Head:

Pain with ☐Nausea/Vomiting ☐Fever/Chills ☐Dizziness ☐Phono/Photophobia ☐Neck Rigidity

Neurologic Deficit ☐Sensation ☐Strength ☐Speech ☐Vision ☐Hearing ☐Cognition ☐Memory ☐Eye Motion/Pupils React

Neck:

Tenderness at _____________ ☐Mild ☐Moderate ☐Severe ☐Worsened. Muscle Spasm ☐Mild ☐Moderate ☐Severe

Postural Abnormalities______________________________ Radiating Pain To________________________________

Functional Limits____

Back:

Tenderness at ________________ ☐Mild ☐Moderate ☐Severe ☐Worsened. Muscle Spasm ☐Mild ☐Moderate ☐Severe

Postural Abnormalities ________________ ☐Scoliosis _____________________ Radiating Pain To_________________________

Functional Limits____

Extremities, Hip(s) and Shoulder(s)

Tenderness at _______________ ☐Mild ☐Moderate ☐Severe ☐Worsened. Muscle Spasm ☐Mild ☐Moderate ☐Severe

Swelling _______________ Color change __________ Deformity ______________ Radiating pain to_________________________

Functional Limits____

Neurologic Deficit Location ___________________________ ☐Weakness ☐Abnormal Sensation ☐Reflexes (Increased/Decreased)

ROM of Affected joint(s) Use measurement or indicate if ROM Within Normal Limits (WNL), mildly, moderately or severely limited:

Joints	Flexion / Extension	Lateral Flexion R / L	Rotation R / L	Rotation Int./Ext.	Abduction / Adduction	Other:

Orthopedic/Neurological Test Findings: E.g., Axial Compression ______ ; Patrick's (Fabere) _______ ; Straight Leg Raising_______

____

Abdominal Pain:

Associate Symptoms: ☐Fever ☐Nausea/Vomit ☐Gas/Distension ☐Heartburn/Reflux ☐Constipation ☐Diarrhea or________

Palpable Mass at ___________________Tenderness at_____________ Rebound Tenderness______________________________

Bowel Movement Sounds (Increase/Decrease)____________________ Other Findings__________________________________

Menstrual Pain: Menstrual Cycle________ days. Other Symptoms____

Additional Clinical Findings (including Lab / Radiographic Exams)____

____

Outcome Assessments (List both Initial and Current date(s) with score(s) for applicable tests)

	Initial	Current
List Date Obtained	____ / ____ / ____	____ / ____ / ____
Roland-Morris score	_______________	_______________
Oswestry score	_______________	_______________
Pain scale (0-10) score	_______________	_______________
Other______________	_______________	_______________

	Initial	Current
List Date Obtained	____ / ____ / ____	____ / ____ / ____
Neck Disability Index score	_______________	_______________
LEFS (Lower Extrem.) score	_______________	_______________
DASH (Upper Extrem.) score	_______________	_______________
Other____________________	_______________	_______________

Signature of treating acupuncture practitioner______________________________ **Examination Date (required)**______________