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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**______________

MNR FORM -Page 2 (OPTIONAL)
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		Initial	Current
List Date Obtained	____ / ____ / ____	____ / ____ / ____	**List Date Obtained**	____ / ____ / ____	____ / ____ / ____
Roland-Morris score	______________	______________	Neck Disability Index score	______________	______________
Oswestry score	______________	______________	LEFS (Lower Extrem.) score	______________	______________
Pain scale (0-10) score	______________	______________	DASH (Upper Extrem.) score	______________	______________
Other______________	______________	______________	Other__________________	______________	______________

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