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*Also Admitted to practice in Florida and Mississippi

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REPORT OF MEDICAL TREATMENT

(to be completed by you – not your doctor)

CLIENT: ____________________ SSN: ____________ DOB: ________ MONTH: _______

DOCTOR'S APPOINTMENT	DOCTOR'S APPOINTMENT
Dates of Visit: __________________________	Dates of Visit: __________________________
Doctor: ________________________________	Doctor: ________________________________
Address: _______________________________ ______________________________________ ______________________________________	Address: _______________________________ ______________________________________ ______________________________________
Phone: ________________________________	Phone: ________________________________
Treated for: ____________________________ ______________________________________ ______________________________________ ______________________________________	Treated for: ____________________________ ______________________________________ ______________________________________ ______________________________________
Testing ☐X-rays ☐MRI ☐EKG ☐Bloodwork ☐CT Scan ☐EEG ☐EMG ☐Breathing tests ☐Other __________________	Testing ☐X-rays ☐MRI ☐EKG ☐Bloodwork ☐CT Scan ☐EEG ☐EMG ☐Breathing tests ☐Other __________________

DOCTOR'S APPOINTMENT	HOSPITAL OR EMERGENCY VISIT
Dates of Visit: __________________________	Name of Hospital: ________________________ City: __________________________________
Doctor: ________________________________	☐Inpatient (dates __________ to __________)
Address: _______________________________ ______________________________________ ______________________________________	☐Outpatient (date __________ to __________) ☐Emergency Room (date __________________)
Phone: ________________________________	Treating/Admitting Doctor: _________________ Other Doctors Seen _______________________
Treated for: ____________________________ ______________________________________ ______________________________________ ______________________________________	Reason for Treatment: _____________________ ______________________________________
Testing ☐X-rays ☐MRI ☐EKG ☐Bloodwork ☐CT Scan ☐EEG ☐EMG ☐Breathing tests ☐Other __________________	Testing ☐X-rays ☐MRI ☐EKG ☐Bloodwork ☐CT Scan ☐EEG ☐EMG ☐Breathing tests ☐Other __________________