PLEASE DO NOT CUT BLUE FORMS

REPORT OF MEDICAL TREATMENT

(*to be completed by you -- not your doctor*)

SSN: _____

CLIENT: _____ MONTH: _____, 20___

DOCTOR'S APPOINTMENT

Date of Visit: _____

Doctor: _____

Address: _____

_____

Phone: _____

Treated for: _____

_____

_____

Testing ❑ X-rays ❑ MRI ❑ EKG
❑ Bloodwork ❑ CTScan ❑ EEG ❑ EMG
❑ Breathing Tests ❑ Other: _____

_____

DOCTOR'S APPOINTMENT

Date of Visit: _____

Doctor: _____

Address: _____

_____

_____

Phone: _____

Treated for: _____

_____

_____

Testing ❑ X-rays ❑ MRI ❑ EKG
❑ Bloodwork ❑ CTScan ❑ EEG ❑ EMG
❑ Breathing Tests ❑ Other: _____

_____

DOCTOR'S APPOINTMENT

Date of Visit: _____

Doctor: _____

Address: _____

_____

_____

Phone: _____

Treated for: _____

_____

_____

Testing ❑ X-rays ❑ MRI ❑ EKG
❑ Bloodwork ❑ CTScan ❑ EEG ❑ EMG
❑ Breathing Tests ❑ Other: _____

_____

HOSPITAL OR EMERGENCY VISIT

Date of Visit: _____

Hospital: _____

City: _____

❑ Inpatient (dates _____ to _____)
❑ Outpatient (dates _____ to _____)
❑ Emergency Room (date: _____)
Treating/Admitting Doctor: _____
Other Doctors seen: _____
Reason for Treatment: _____

_____

Testing ❑ X-rays ❑ MRI ❑ EKG
❑ Bloodwork ❑ CTScan ❑ EEG ❑ EMG
❑ Breathing Tests ❑ Other: _____

_____

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