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REPORT OF MEDICAL TREATMENT

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

	SSN:
CLIENT:	MONTH:, 20
DOCTOR'S APPOINTMENT	DOCTOR'S APPOINTMENT
Date of Visit:	Date of Visit:
Doctor:	Doctor:
Address:	Address:
Phone:	Phone:
Treated for:	Treated for:
Testing □ X-rays □ MRI □ EKG □ Bloodwork □ CTScan □ EEG □ EMG □ Breathing Tests □ Other:	Testing □ X-rays □ MRI □ EKG □ Bloodwork □ CTScan □ EEG □ EMG □ Breathing Tests □ Other:
DOCTOR'S APPOINTMENT	HOSPITAL OR EMERGENCY VISIT
Date of Visit:	Date of Visit:
Doctor:	Hospital:
Address:	City:
Phone:	☐ Inpatient (dates to) ☐ Outpatient (dates to) ☐ Emergency Room (date:) Treating/Admitting Doctor:
	Other Doctors seen:
Treated for:	Reason for Treatment:
Testing □ X-rays □ MRI □ EKG □ Bloodwork □ CTScan □ EEG □ EMG □ Breathing Tests □ Other:	Testing □ X-rays □ MRI □ EKG □ Bloodwork □ CTScan □ EEG □ EMG □ Breathing Tests □ Other:

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