UPLEDGER INSTITUTE INTERNATIONAL

TREATMENT SUMMARY

Please Note:

Continue to fill out in full:

1. **Patient History.** (If the patient has been in the program before and they have given us a history on their last visit - refer to this in the history section and note any medical history since the last visit. The prior summary should be in their file.)
2. **Current level of function.** Please be detailed here. (We want to be able to note any changes in function during their stay in the program and to refer to functional challenge daily during treatment)
3. **Patient/family goals.** This is very important so that we may address their goals throughout their stay.
4. **CranioSacral Rhythm** section of the Clinical Observations/Assessment section.

For the remainder of the Clinical Observations/Assessment section please list the major areas of restriction. You do not need to fill out each line - only the ones that you feel are significant.

****The therapist filling out the Post Treatment section must refer to the findings in the Pre Treatment section.**

**** Remember to sign the document Thank You**

TREATMENT SUMMARY

Patient Name:_____Date of Birth:_____

Dates of Treatment:_____

Medical History: (Include diagnoses, symptoms, past medical conditions, illnesses, or injuries, prior medical procedures/treatment, birth history, etc., as applicable)

Patient is a _____ year old (circle one) male/female who presents with the following medical history:

_____

_____

_____

_____

_____

_____

Current level of function: (living situation, self care, functional abilities, activity related pain)

_____

_____

Patient/family goals: (what changes patient/family desire, why they came to IP, as stated by patient or family)

_____

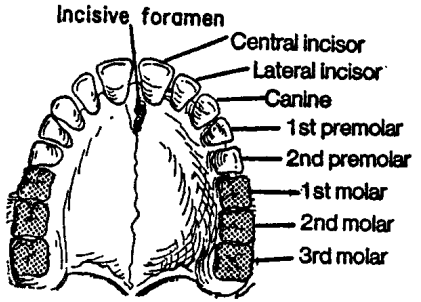
_____

Clinical Observations/Assessment Fill in all areas with the description and the level of restriction or dysfunction. If there is no restriction or dysfunction write in "no dysfunction". Use the terms "mild, moderate or severe" to denote degree of dysfunction, restriction, lesion and pain level. Note percentage of change on the Post Evaluation section: 0-mild=30%, mild-moderate=30%, moderate-severe=30%. You may use percentages of these, i.e., a change from moderate to mild/moderate=15%, a change from severe to 0/mild=75%. Do not leave any area blank.

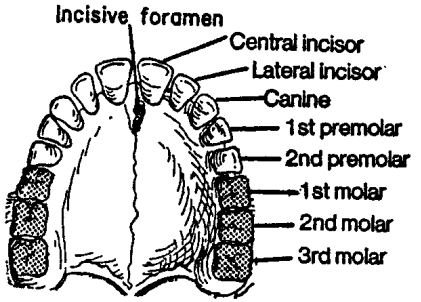
CranioSacral Rhythm	**Initial**	**Post**
Symmetry (range of motion response to flexion and extension phases)		
Quality (description of system, i.e., erratic, sluggish, constricted, thick, dry, labored, etc.)		
Amplitude (degree of force/power within the system, i.e., moderately low, mild restriction in flexion		
Rate (cycles per minute)		
Transverse Diaphragms (describe the patterns and levels of restriction, i.e., severe torsion left)	i	
Pelvic		
Respiratory		
Thoracic		
Hyoid		
OCB		

	Initial	Post
Dural Tube (describe the position and level of Restrictions, i.e., moderate left/posterior aspect of C2) (describe position of facilitated segments, i.e., L2) Restrictions		
Facilitated Segments		
Intracranial Membrane System (describe patterns and degrees of restrictions within the IC Membrane System, i.e., moderate anterior/ medial strain of left tentorium cerebelli)		
Cranial Vault (use the standard lesion pattern descriptions with degree of restriction, i.e., severe left lateral strain, moderate flexion lesion, mild restriction of right occipitomastoid region) Frontal		•
Left Parietal		
Right Parietal		
Sphenoid		
Left Temporal		
Right Temporal		
Occiput		

	Initial	Post
Facial Bones/Hard Palate/Teeth (use the standard Lesion pattern descriptions with degree of restriction, i.e., severe extension lesion, moderate anterior strain) Left zygoma		
Right zygoma		
Left maxilla		
Right maxilla		
Vomer		
Left Palatine		
Right Palatine		
Left Nasal		
Right Nasal		
Mandible		
TMJ		
Teeth		



Arcata Dentale Superiore



Arcata Dentale Inferiore

	Initial	Post
Sacrum (describe lesion pattern with degree of restriction, i.e., severe torsion left with moderate left lateral strain		
Meridians (identify the meridians that are restricted In flow and energy, i.e., severe energy blockage of Kidney) Lung/Large Intestine		
Spleen/Stomach		
Heart/Small Intestine		
Kidney/Bladder		
Circulation/Triple Heater		
Liver/Gall Bladder		
Chakras (quality, spin, position, dysfunction) 1		
2nd		
3rd		
4^{th}		
5*		
7^{th}		
Body Chart Vectors (position, breaks that occur, quality, strength/weakness)		

	Initial	Post
Energy Cyst(s) (location)		
Fascial Glide Restrictions (areas, quality, Pathways)		
Other Observations (Suggested areas to observe and note <u>if significant:</u> gait, balance, poise, mobility, strength/weakness, range of motion, fine and gross motor skills, mastication, swallowing, eye movement, eye contact, language skills, attentiveness, ability, to focus, quality of breathing, activity level, pain/ discomfort level (location, position, frequency, duration), emotional state (happy, sad, frustrated, angry, etc.) and energy level.		

Treatment
Services provided included:

___CranioSacral Therapy
___Myofascial Release
___Visceral Manipulation
___Osteopathic intervention
___Vibrational therapy
___Neuromuscular Re-education
___SomatoEmotional Release
___Kinetic Activities
___Acupuncture
___Lymphatic Drainage
___Patient/Family Education: _____
___Autogenic training, visualization, progressive relaxation
___Other:_____

Summary
Response to treatment: (changes observed/reported, progress towards goals)

_____

_____

_____

_____

_____

_____

Recommendations:

___To continue with your CST therapist at home
___Participate in at home CST per IP therapists' instructions ___ times per week
___It is suggested that in 4-6 weeks that your OT, PT or Speech Therapist re-evaluate your current program

___Return to the IP as needed

_____

_____

_____

_____

_____

_____

Therapist Signature/Name _____ Date _____

Therapist Signature/Name _____ Date _____

IPXM3