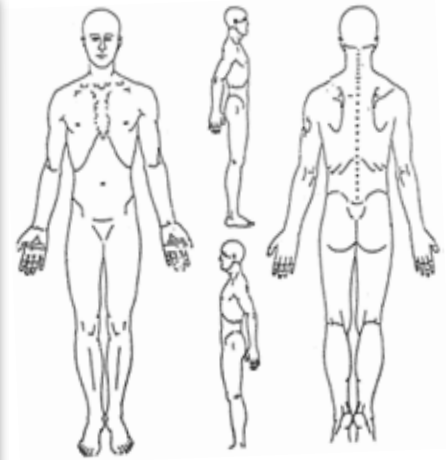


Name: _____ Date: _____

Any new injuries, accidents, falls, or trauma since your last visit? Yes No
 If yes, explain: _____
Have you seen any other health care providers since your last visit: Yes No
 If yes, who: _____ and why: _____
On the diagram, please mark ALL areas where you are experiencing symptoms. →
 Pain Spasm Ache Numbness/Tingling Weakness Sharp/Stabbing
 Please circle your current level of pain or discomfort: 0 1 2 3 4 5 6 7 8 9 10
 Since last visit I am feeling: Better Better until recently Unchanged Worse
Which specific activities of daily life are you currently having difficulty with?
 i.e.: Work Bending Lifting Housework Walking Exercise Sitting Sleeping Computer
 Use Other _____ How?



CMT	SPINAL REGIONS						EXTRASPINAL REGIONS			
Objective Findings	Cervical	Thoracic / Ribs	Lumbar	Sacrum	Pelvis	Hip	Knee	Shoulder	Other	
Pain/Tenderness	Occ 1 2 3 4 5 6 7	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5	R / L	R / L	R / L	R / L	R / L		
Asymmetry/Misalignment Listings:	Occ 1 2 3 4 5 6 7	1 2 3 4 5 6 7 8 9 10 11 12 PL PR PL PR -S -I -T S -I -T	1 2 3 4 5 PL PR -S -I -M	PR / PL PIR / PIL	R / L PI / AS IN / EX	Femur: INF SUP IN / EXT	Tib Fib Patella _____	Hum Clav Scap Inf Sup Int Ext A P		
Taut/Tender Fibers/ Trigger Points:	Occ 1 2 3 4 5 6 7 Scal Lev SCM	1 2 3 4 5 6 7 8 9 10 11 12 Trap Rhomb Para Lat	1 2 3 4 5 QLs Multi	R / L Gl. Med/Max	R / L Piriform	ITB Psoas Iliacus	Add Sart Pop Quad	Delt Biceps Sub Inf TM Sup		
Edema/Inflammation	Occ 1 2 3 4 5 6 7	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5	R / L	R / L					
<input checked="" type="checkbox"/> ROM- Active/ Passive Short Leg: R L PP PN	Occ 1 2 3 4 5 6 7 Rot Flx Ext LF	1 2 3 4 5 6 7 8 9 10 11 12 Rot Flx Ext LLF RLF	1 2 3 4 5 Flx Ext LF	R / L Flex Ext	R / L Flex Ext	R / L ABd Rot	R / L Flx	R / L ABd _____°		

ASSESSMENT

Since last visit: Improved (____%) Unchanged Worse **Prognosis:** Guarded Good MMI

Additional Notes: _____

Diagnosis: _____

PLAN / RECOMMENDATIONS

NP Exam: 99201 99202 99203 **Est. Pt Exam:** 99211 99212 99213 99214

Chiropractic Manipulation/Adjustment: CMT 1-2 (98940) CMT 3-4 (98941) CMT 5 (98942) Extremity (98943)

CS: Occ 1 2 3 4 5 6 7 **TS:** 1 2 3 4 5 6 7 8 9 10 11 12 **LS:** 1 2 3 4 5 **SAC:** R / L **SI:** R / L **Shoulder:** R / L **Elbow:** R / L **Wrist:** R / L **Hip:** R / L **Knee:** R / L **Ankle:** R / L

Today's Subluxations/Joint Fixations were adjusted: prone diversified drop instrument side posture supine seated

- 97140 Manual Therapy (Myofascial Man. Tx Mobil) Time MT: _____ 97124 Massage Therapy Time: _____
- 97032 Electrical Stimulation - Hz: _____ 97010 Heat/Ice
- S8948 Low Level Laser Therapy Areas: _____ Time: _____
- 97110 Therapeutic Exercise CS TS LS Pelvis Other: _____ Ball Weights Iso WBV Time: _____
- 97112 Neuromuscular Re-Education Time: _____ 97535 ADL Description: _____ Time: _____
- Treatment was tolerated well Patient felt better Nutrition/Support: _____

The following recommendations are made with regard to the ongoing Clinical Management of this patient:

Continue Care Plan Return in/on _____ PRN Discharge Referral made to: _____
Total Charges: _____ **Payment:** CC Check Cash Paypal

Doctor's Signature: _____ **Date:** _____