Patient Name: _____

ADVANCE NOTICE OF NONCOVERAGE/PATIENT RESPONSIBLE

Your insurance may not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance may not pay for the ***checked items*** below. You are ultimately responsible for payment.

Service(s): Check those that apply	***(F)* Estimated Cost:**
☐ Massage Therapy per LMT ☐ Ancillary modalities ☐ Electrodes/reusable pads ☐ Other:	☐ $10 per visit ☐ $15 per visit ☐ $8 per set of 4 pads ☐ $____

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.

OPTIONS:	**Check only one box. We cannot choose a box for you.**

❑ **OPTION 1.** I **want** the services listed above.

❑ **OPTION 2.** I **don't want** the services listed above listed above.

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	**Date:**

HEALTH FIRST REHAB, INC
dba Lewis Bay Chiropractic

Patient Name:
Patient D.O.B.:

Chiropractic Physician
☐ Robert Harmon, DC
☐ Joshua Lindauer, DC
☐ Michelle Starr, DC

Informed Consent for
Chiropractic Services

I have been <u>informed</u> of the following:

1. By signing below, I consent to the services being rendered during this visit by the above-named chiropractic physician (s) or any other chiropractic physician who now or in the future treat me while employed by, working or associated with or covering for the above-named chiropractic physician.
2. I have been informed that the process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (ribs, legs, arms etc.), often, but not necessarily resulting, in an audible pop or clicking sound;
3. I have been informed that in addition to the Chiropractic Adjustment, one or more "Supportive Therapies" may be applied by the chiropractor or by staff under their direction and supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, heat, cold, and/or nutritional/lifestyle recommendations;
4. I have been informed that coinciding with the process of a Chiropractic Adjustment and/or Supportive Therapies there may be, at times, some temporary soreness and/or stiffness; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely tissue bruising and/or swelling, more rare joint/bone separation/fracture; and extremely rare, disc, nerve or vascular injury;
5. I have been informed that at times treatment techniques may include skin to skin contact, tissue mobilization and/or stretching of involved or related areas and digital pressure/light touch/brushing over regions both on and/or away from your primary complaint location;
6. I have been informed that certain techniques may require close proximity between clinician and patient;
7. I have been informed of my condition, possible benefits, risks of treatment if any, options, and financial obligations;
8. I have been informed that it is my responsibility to inform the chiropractor of any condition(s) that would otherwise not come to their attention;
9. I have been informed that the chiropractor has made no guarantee of a positive outcome from treatment; and
10. I have been afforded ample opportunity for questions and answers.

<u>Therefore, by signing below:</u>

I <u>consent</u> to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I <u>consent</u> to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature:_____ Date:_____

Guardian Name (if applicable):_____

Guardian Signature (if applicable):_____Date:_____

Witness Signature:_____Date:_____

Office Policies - Health First Rehab, Inc.

dba. Lewis Bay Chiropractic

Patient Messaging Consent

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications via an automated outreach and messaging system. I also authorize my healthcare provider to disclose to third parties who may intercept these messages (individuals you have provided with access to your digital devices or email accounts) limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from the automated outreach and messaging system, when necessary.

Privacy Notice Acknowledgement

In accordance with the ***Health Insurance Portability and Accountability Act of 1996 (HIPAA)***, by signing below, I acknowledge that a copy of the Notice of Privacy Practices for Protected Health Information for this office has been made available to me. I am advised to read this document carefully, for it outlines the use and limitations of the disclosure of my health information and my rights as a patient. I have been given the opportunity to ask any questions that I may have regarding these policies.

Authorization to Release Medical Information

I authorize my healthcare provider(s) to furnish information from my medical records to any company that may be responsible for payment of all or part of my visit and provider charges, including my insurance companies and their representatives, and my information to this provider for continuing care.

Massage Therapy Non-Covered Service Waiver

Massage therapy services performed by a licensed massage therapist in this office are not a covered benefit under your current health plan, as these procedures are not performed directly by a participating physician/provider.

There is a fee of ***$10.00*** per visit for this service. _____**Initial**

Authorization for Direct Payment of Insurance Benefits

I, or my representative, authorize direct payment to the provider(s) and/or clinic rendering any services during this visit of any insurance benefits otherwise payable to me.

Health Insurance/Patient Payment Policy

We will file your insurance claims for you. However, we cannot guarantee or take responsibility for what your health insurance will or will not cover. Ultimately, all services rendered to you are charged directly to you and you are personally responsible for payment. Payment for all services, including copays, coinsurance and deductibles, are expected at the time of service unless prior arrangement are made with us. **If you have a cash balance with our office greater than *45 days*, there will be a finance charge of *5% per month applied to your account***.

Treatment Compliance. Appointment Cancellation Policy

We require 24 hour notice for patient cancellations. Health First Rehab, INC reserves the right to charge *$60* for missed appointments if this policy is abused. This amount is not covered by any insurance plan and will be the patient's responsibility. Further, **greater than 2 missed appointments will be considered non-compliance and subject to discharge from care**.

_____**Initial**

I have read the Health First Rehab, Inc. office policies and will honor them:

Print Name	**Patient Signature**	**Date**

Patient Information

Date:_____

Name: DOB:

Address:

Town: State: Zip:

Home Phone: Cell #:

E-mail address:

Social Security # - -

Marital Status:

Emergency Contact:

Relation: Phone:

Occupation:

Primary Care MD:

Permission to send treatment notes: Yes NO

PATIENT PAIN FORM

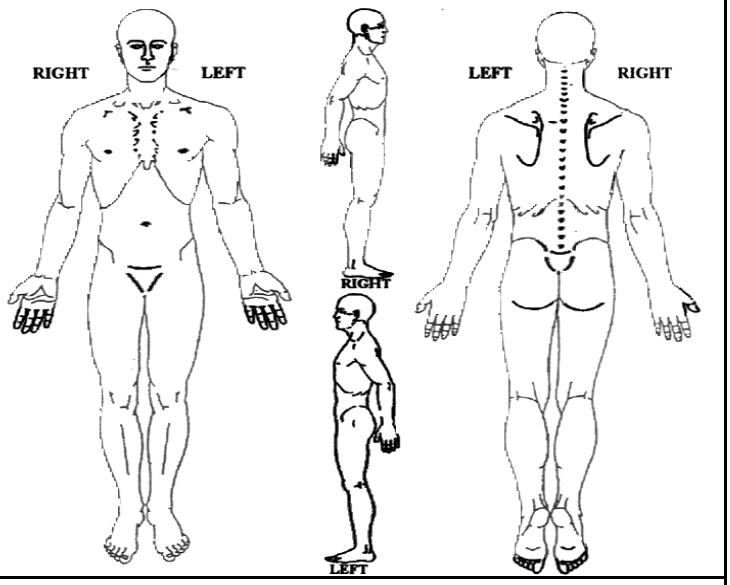
Health First Rehab, INC
dba Lewis Bay Chiropractic

Patient: _____ **Date of Birth:**_____ **Today's Date:** _____

☐ **MVC** ☐ **WC Date of Injury (if applicable):** _____

SHOW US YOUR PAIN
USE THE LETTERS BELOW TO INDICATE THE TYPE
AND LOCATION OF YOUR SYMPTOMS TODAY

KEY: **A** = ACHE **B** = BURNING **N** = NUMBNESS **P** = PINS & NEEDLES
S = STABBING **X** = STIFFNESS **T** = THROBBING **O** = OTHER



0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Worst Pain)

1. When did your symptoms first begin?

2. What caused your recent symptoms?

3. Is this an exacerbation of a chronic condition?

☐ **Yes** ☐ **No**

4. Have you had these symptoms in the past?

☐ **Yes** ☐ **No**

Please sign Here:

I experience the above symptoms: ☐ Constantly ☐ Very Often ☐ Occasionally ☐ Infrequently

I feel that my symptoms are: ☐ Getting Better ☐ Getting Worse ☐ Staying About the Same

My symptoms are: ☐ Dull, Achy ☐ Stiffness ☐ Sharp/stabbing ☐ Burning ☐ Throbbing ☐ Numbness ☐ Tingling/Pins and needles

Symptoms radiate/refer to my: ☐ Head ☐ Shoulders (B R L) ☐ Both arms ☐ Right arm ☐ Left Arm ☐ Flank/ribs ☐ Hips (B R L) ☐ Buttocks (B R L) ☐ Both Legs ☐ Left leg ☐ Right Leg

Symptoms are worse with: ☐ Standing ☐ Sitting ☐ Driving ☐ Bending ☐ Lifting ☐ Work Activity

Other, please explain:

Symptoms are relieved with: ☐ Rest/Lying down ☐ Ice ☐ Heat ☐ Stretching ☐ Movement ☐ Massage ☐ Other, please explain:

I am unable to perform the following activities due to pain:

List current medications/Supplements: ☐ See current medication list provided

1. 2. 3. 4. 5.

I am experiencing the following symptoms (please check all that apply) :

☐ Shortness of breath
☐ Difficulty breathing
☐ Pain with coughing
☐ Bowel/bladder changes
☐ Urinary incontinence
☐ Blood in stool
☐ Other symptoms:

☐ Nausea /Vomiting
☐ Fevers / Chills
☐ Light-headed, dizziness
☐ Visual changes
☐ Hearing changes
☐ "Foggy/Hazy" feeling

☐ Difficulty sleeping
☐ Difficulty concentrating
☐ Memory problems
☐ Mood swings, irritability
☐ Loss of appetite/Weight loss
☐ Fatigue

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Personal Care

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but I manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours sleepless).

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything at all.

Reading

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I cannot read as much as I want because of moderate neck pain.
- ☐ I can hardly read at all because of severe neck pain.
- ☐ I cannot read at all because of neck pain.

Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight neck pain.
- ☐ I can drive my car as long as I want with moderate neck pain.
- ☐ I cannot drive my car as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I cannot drive my car at all because of neck pain.

Concentration

- ☐ I can concentrate fully when I want with no difficulty.
- ☐ I can concentrate fully when I want with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating when I want.
- ☐ I have a lot of difficulty concentrating when I want.
- ☐ I have a great deal of difficulty concentrating when I want.
- ☐ I cannot concentrate at all.

Recreation

- ☐ I am able to engage in all my recreation activities without neck pain.
- ☐ I am able to engage in all my usual recreation activities with some neck pain.
- ☐ I am able to engage in most but not all my usual recreation activities because of neck pain.
- ☐ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ☐ I can hardly do any recreation activities because of neck pain.
- ☐ I cannot do any recreation activities at all.

Work

- ☐ I can do as much work as I want.
- ☐ I can only do my usual work but no more.
- ☐ I can only do most of my usual work but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Calculate Score

Score

Neck

Back Index

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is very severe and does not vary much.

Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain my normal sleep is reduced by less than 25%.
- ☐ Because of pain my normal sleep is reduced by less than 50%.
- ☐ Because of pain my normal sleep is reduced by less than 75%.
- ☐ Pain prevents me from sleeping at all.

Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain while standing but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases pain immediately.

Walking

- ☐ I have no pain while walking.
- ☐ I have some pain while walking but it doesn't increase with distance.
- ☐ I cannot walk more than 1 mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

Personal Care

- ☐ I do not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain I am unable to do some washing and dressing without help.
- ☐ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.

Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling but none of my usual forms of travel make it worse.
- ☐ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ☐ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ☐ Pain restricts all forms of travel except that done while lying down.
- ☐ Pain restricts all forms of travel.

Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

Changing degree of pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow.
- ☐ My pain is neither getting better or worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Calculate Score

Index Back Score

Patient Name: _____ Date:_____

Always Correlate Symptoms with PPF form filled out by patient!!!

1. **New patient 1st visit or New injury** : N **Y: PPF**, perform comprehensive exam.
   or
2. **Exacerbations since last treatment**? N **Y:PPF,** MOI: _____
   (Reset Treatment Plan!!)

Rx. for complaints ? **Tylenol, ibuprofen, aleve, muscle relaxant, steroid other:** _____

NP NRS: 0 1 2 3 4 5 6 7 8 9 10/10 **Cough?** (+) (-) **Since last tx?** Better Worse Same

B R L **RR?** BUE RUE LUE – sh elbow hand fingers **N. Root**: C4 C5 C6 C7 C8 T1

N / T / W ? BUE RUE LUE **N. Root:** C4 C5 C6 C7 C8 T1

HA NRS: 0 1 2 3 4 5 6 7 8 9 10/10 **Since last tx?** Better Worse Same

B R L **Type:** occipital parietal temporal frontal other : _____

N / T / W ? occipital parietal temporal frontal other: _____

RED FLAGS ? Nausea Vomiting Dizziness Light headed Slurred speech

SHOULDER NRS: 0 1 2 3 4 5 6 7 8 9 10/10 **Since last tx?** Better Worse Same

B R L **Radiation Referral?** BUE RUE LUE - elbow hand fingers

N / T / W? BUE RUE LUE **Distribution?**: TOS Radial Median Ulnar

ELB WRIST HD NRS: 0 1 2 3 4 5 6 7 8 9 10/10 **Since last tx?** Better Worse Same

B R L **Radiation Referral?** elbow hand fingers

N / T / W? BUE RUE LUE - elbow hand fingers

Distribution?: Radial Median Ulnar

MBP NRS: 0 1 2 3 4 5 6 7 8 9 10/10 **Cough?** (+) (-) **Since last tx?** Better Worse Same

B R L **Radiation Referral?** Flank B R L Ribs B R L Chest B R L

Difficulty breathing shortness of breath **N / T / W?:** B R L

LBP NRS: 0 1 2 3 4 5 6 7 8 9 10/10 **Cough?** (+) (-) **Since last tx?** Better Worse Same

B R L **RR?** BLE RLE LLE - buttock shin calf foot/toes **N. Root?**: L1 L2 L3 L4 L5 S1

N / T / W? BLE RLE LLE - buttock shin calf foot/toes **N. Root?**: L1 L2 L3 L4 L5 S1

SI NRS: 0 1 2 3 4 5 6 7 8 9 10/10 **Since last tx?** Better Worse Same

B R L **Radiation Referral?** Groin B R L **N / T / W?** BLE RLE LLE

SAC/COC NRS: 0 1 2 3 4 5 6 7 8 9 10/10 **Since last tx?** Better Worse Same

B R L **Radiation Referral?** BLE RLE LLE **Groin** B R L **N / T / W?** BUE RUE LUE

HIP NRS: 0 1 2 3 4 5 6 7 8 9 10/10 **Since last tx?** Better Worse Same

B R L **Radiation Referral?** BLE RLE LLE

N / T / W? BLE RLE LLE **Distribution?**: TOS Radial Median Ulnar

Knee FT ANK NRS: 0 1 2 3 4 5 6 7 8 9 10/10 **Since last tx?** Better Worse Same

B R L **Radiation Referral?** calf achillies shin foot toes

N / T / W? calf achillies shin foot toes **N. Distribution?:** Fib. Tib Ant Tib Post.

Name: _____ **Date of Birth:** _____ **DOI:** _____

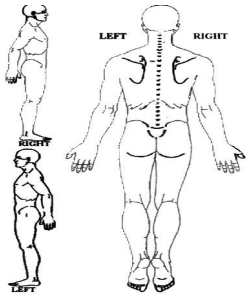
Vitals: HT: WT: TEMP: HR: BP:

PRESENTATION

Weight?	☐ Normal ☐ Slightly Overweight ☐ Overweight ☐ Obese
Conditioning?	☐ Normal ☐ Deconditioned
Pain Distress?	☐ No ☐ Mild ☐ Moderate ☐ Severe
Alert and Oriented?	☐ Yes ☐ No:
Slurred speech, facial asymmetry or delay in mentation?	☐ No ☐ Yes:
Degree of Difficulty Transitioning Positions	☐ No ☐ Slight ☐ Mild ☐ Moderate ☐ Severe
Ambulates Without Assistance	☐ Yes ☐ No – Assist Device? ☐ Cane ☐ Walker ☐ Wheelchair bound
Ataxia, Limp or Antalgia?	☐ No ☐ Yes: ☐ Ataxia ☐ Limp R L ☐ Antalgia R L

POSTURE

Cervical	☐ Slight FHC ☐ FHC ☐ UCS ☐ LLF head ☐ RLF head
Shoulders	☐ Sh's Level ☐ **R** tilt shoulder ☐ **L** tilt shoulder ☐ Hand Dominance? **R L** ☐ Scapular Winging **R L** ☐ Interscap. distance = R L ☐ Poor Scap/hum rhythm **L R**
Thoracic	☐ Dowager's ☐ Hyperkyphosis ☐ Hypokyphosis ☐ Scapular Winging **B R L** ☐ ADAM's/Scoliosis: Apex **R L** ☐ Rib Hump **R L** ☐ Other findings:
Lumbar	☐ FCT ☐ Hyperlordosis ☐ Hypolordosis ☐ **L** Antalgia ☐ **R** Antalgia
Pelvic	☐ Right short leg ☐ Right tilt pelvis ☐ Left short leg ☐ Left tilt pelvis ☐ Anterior pelvis **B R L** ☐ Posterior pelvis **B R L**
Lower Extremities	☐ Gen valgus **B R L** ☐ Gen varus **B R L** ☐ Achilles bow **B R L** ☐ Pes Planus **B R L**
Other Findings	☐ Adam's (scoliosis)/



RANGE OF MOTION (T = tight)

Csp	WNL ☐ LROM (limited Range of Motion)	P (px)	Location?	RR to UE's?	N/T UE's?	Location?
Flex	☐ 0 5 10 15 20 25 30 35 40 45 50/50	T 0 1 2 3	**NP** B R L	☐ No B R L	☐ No B R L	Sh elb wrist hand/fing
Ext	☐ 0 5 10 15 20 25 30 35 40 45 50 55 60 /60	T 0 1 2 3	**NP** B R L	☐ No B R L	☐ No B R L	Sh elb wrist hand/fing
LLF	☐ 0 5 10 15 20 25 30 35 40 45/45	T 0 1 2 3	**NP** B R L	☐ No B R L	☐ No B R L	Sh elb wrist hand/fing
RLF	☐ 0 5 10 15 20 25 30 35 40 45 /45	T 0 1 2 3	**NP** B R L	☐ No B R L	☐ No B R L	Sh elb wrist hand/fing
LR	☐ 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80/80	T 0 1 2 3	**NP** B R L	☐ No B R L	☐ No B R L	Sh elb wrist hand/fing
RR	☐ 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80/80	T 0 1 2 3	**NP** B R L	☐ No B R L	☐ No B R L	Sh elb wrist hand/fing
Thoracic	☐ Scapular Protraction	T 0 1 2 3	**MB** B R L	☐ No B R L	☐ No B R L	Flank ribs chest
	☐ Scapular Retraction	T 0 1 2 3	**MB** B R L	☐ No B R L	☐ No B R L	Flank ribs chest

TLsp	WNL ☐ LROM (limited Range of Motion)	P (px)	Location?	RR to LE's?	N/T UE's?	Location?
Flex	☐ 20 25 30 35 40 45 50 55 60 65 70 75 80 85/85	T 0 1 2 3	**LB** B R L	☐ No B R L	☐ No B R L	Hip knee ankle foot
Ext	☐ 0 5 10 15 20 25/25	T 0 1 2 3	**LB** B R L	☐ No B R L	☐ No B R L	Hip knee ankle foot
LLF	☐ 0 5 10 15 20 25 30 35/35	T 0 1 2 3	**LB** B R L	☐ No B R L	☐ No B R L	Hip knee ankle foot
RLF	☐ 0 5 10 15 20 25 30 35/35	T 0 1 2 3	**LB** B R L	☐ No B R L	☐ No B R L	Hip knee ankle foot
LR	☐ 0 5 10 15 20 25 30 35 40 45/45	T 0 1 2 3	**LB** B R L	☐ No B R L	☐ No B R L	Hip knee ankle foot
RR	☐ 0 5 10 15 20 25 30 35 40 45/45	T 0 1 2 3	**LB** B R L	☐ No B R L	☐ No B R L	Hip knee ankle foot

SH R L	WNL	Px
Flex	☐ /180	T 0 1 2 3
Ext	☐ /50	T 0 1 2 3
ABD	☐ /180	T 0 1 2 3
ADD	☐ /50	T 0 1 2 3
IR	☐ /90	T 0 1 2 3
ER	☐ /90	T 0 1 2 3

HIP R L	WNL	Px
Flex	☐ /180	T 0 1 2 3
Ext	☐ /50	T 0 1 2 3
ABD	☐ /180	T 0 1 2 3
ADD	☐ /50	T 0 1 2 3
IR	☐ /90	T 0 1 2 3
ER	☐ /90	T 0 1 2 3

KNEE R L	WNL	Px
Flex	☐ /110	T 0 1 2 3
Ext	☐ /0	T 0 1 2 3
ANK R L	**WNL**	**Px**
Dorsi	☐ /20	T 0 1 2 3
Plantar	☐ /45	T 0 1 2 3
Inversion	☐ /20	T 0 1 2 3
Eversion	☐ /10	T 0 1 2 3

ELB R L	WNL	Px
Flex	☐ /140	T 0 1 2 3
Ext	☐ /0	T 0 1 2 3
Supin	☐ /80	T 0 1 2 3
Pronat	☐ /80	T 0 1 2 3
Wrist R L	**WNL**	**Px**
Flex	☐ /60	T 0 1 2 3
Ext	☐ /60	T 0 1 2 3
Rad dev	☐ /20	T 0 1 2 3
Uln dev	☐ /10	T 0 1 2 3

ORTHOPEDIC

CTsp	(-)	P (px)	Location?	RR to UE's?	N/T UE's?	Location?
Px w/ Cough?	☐	T 0 1 2 3	NP B R L	☐No B R L	☐No B R L	Sh elb wrist hand/fing
Lindner's	☐	T 0 1 2 3	NP B R L	☐No B R L	☐No B R L	Sh elb wrist hand/fing
Sh Shrugs (XI)	☐	T 0 1 2 3	NP B R L	☐No B R L	☐No B R L	Sh elb wrist hand/fing
Sh Depress	☐	T 0 1 2 3	NP B R L	☐No B R L	☐No B R L	Sh elb wrist hand/fing
Csp Compress	☐	T 0 1 2 3	NP B R L	☐No B R L	☐No B R L	Sh elb wrist hand/fing
Lat Compress	☐	T 0 1 2 3	NP B R L	☐No B R L	☐No B R L	Sh elb wrist hand/fing
MAIGNE'S	☐	T 0 1 2 3	NP B R L	☐No B R L	☐No B R L	Sh elb wrist hand/fing
MFE	☐	T 0 1 2 3	NP B R L	☐No B R L	☐No B R L	Sh elb wrist hand/fing
Csp Distract	☐	T 0 1 2 3	NP B R L	☐No B R L	☐No B R L	Sh elb wrist hand/fing
T Persussion	☐	T 0 1 2 3	NP B R L	☐No B R L	☐No B R L	Sh elb wrist hand/fing
Inspir/Expir	☐	T 0 1 2 3	NP B R L	☐No B R L	☐No B R L	Sh elb wrist hand/fing
Resist Inspir	☐	T 0 1 2 3	NP B R L	☐No B R L	☐No B R L	Sh elb wrist hand/fing
Bakody	☐	T 0 1 2 3	NP B R L	☐No B R L	☐No B R L	Sh elb wrist hand/fing
Adson's	☐ negative ☐ (+) R L (TOS)					
Other:						

Shoulder L R	(-)	P (px)
Sulcus Test	☐	T 0 1 2 3
Dawburn's	☐	T 0 1 2 3
AC compression	☐	T 0 1 2 3
Codman's drop arm	☐	T 0 1 2 3
Supraspinatus stress	☐	T 0 1 2 3
Infraspinatus stress	☐	T 0 1 2 3
Subscapularis stress	☐	T 0 1 2 3
Teres minor stress	☐	T 0 1 2 3
Yergason's	☐	T 0 1 2 3
Crank Test	☐	T 0 1 2 3
SLAP test (Obrien's)	☐	T 0 1 2 3
Wright's TOS	☐	☐ (+) R L TOS
Elbow/Wrist L R	**(-)**	**P (px)**
Phalen's Prayer	☐	☐ (+) L R
N. Tap: med ulnar	☐	☐ (+) L R

Lumbopelvic	(-)	P (px)	Location?	RR to UE's?	N/T UE's?	Location?
Minor's	☐ absent ☐ present					
Px w/ cough?	☐	T 0 1 2 3	LBP B R L	☐ No B R L	☐ No B R L	Hip knee ankle foot
Lindner's	☐	T 0 1 2 3	LBP B R L	☐ No B R L	☐ No B R L	Hip knee ankle foot
Kemp's	☐	T 0 1 2 3	LBP B R L	☐ No B R L	☐ No B R L	Hip knee ankle foot
SI compress	☐	T 0 1 2 3	SI B R L	☐ No B R L	☐ No B R L	Hip knee ankle foot
Iliac compress	☐	T 0 1 2 3	LB / P B R L	☐ No B R L	☐ No B R L	Hip knee ankle foot
Bechterew's	☐	T 0 1 2 3	LBP B R L	☐ No B R L	☐ No B R L	Hip knee ankle foot
Braggard's	☐	T 0 1 2 3	LBP B R L	☐ No B R L	☐ No B R L	Hip knee ankle foot
SLR Right	☐	T 0 1 2 3	LBP@ _____deg	☐ No B R L	☐ No B R L	Hip knee ankle foot
SLR Left	☐	T 0 1 2 3	LBP@ _____deg	☐ No B R L	☐ No B R L	Hip knee ankle foot
Bowstring	☐	T 0 1 2 3	LBP B R L	☐ No B R L	☐ No B R L	Hip knee ankle foot
FABER's	☐	T 0 1 2 3	HIP B R L	☐ No B R L	☐ No B R L	Hip knee ankle foot
Sacral compress	☐	T 0 1 2 3	LS B R L	☐ No B R L	☐ No B R L	Hip knee ankle foot
Lsp compress	☐	T 0 1 2 3	LBP B R L	☐ No B R L	☐ No B R L	Hip knee ankle foot
Nachlas	☐	T 0 1 2 3	LB / P B R L	☐ No B R L	☐ No B R L	Hip knee ankle foot
Hibb's	☐	T 0 1 2 3	HIP B R L	☐ No B R L	☐ No B R L	Hip knee ankle foot
Yeoman's	☐	T 0 1 2 3	Psoas B R L	☐ No B R L	☐ No B R L	Hip knee ankle foot

(LB / P = LBP or Pelvic px)

Knee L R	(-)	(+)	Indication?
Swelling	☐	☐	
Ballotment	☐	☐	
Patellar Grind	☐	☐	Chondromal.
Valgus Stress	☐	☐	LM MCL
Varus Stress	☐	☐	MM LCL
ANT Drawer	☐	☐	ACL
POST Drawer	☐	☐	PCL
Apley Compression	☐	☐	MM LM
Apley Distraction	☐	☐	MCL LCL
OTHER TESTS NOT LISTED:			

NEUROLOGICAL ☐ unremarkable

Neuro Tests	Intact
PERRLA (III)	☐ Y ☐ N
Cardinal Fields (III, IV, VI)	☐ Y ☐ N
Raise brows/Frowns (VII)	☐ Y ☐ N
Tongue to Cheek (XII)	☐ Y ☐ N
Finger Tapping	☐ Y ☐ N
Finger to Nose (cer)	☐ Y ☐ N
Alt pron/supination hands	☐ Y ☐ N
Graphesthesia	☐ Y ☐ N
Stereognosis	☐ Y ☐ N
Spells "World" Backwords	☐ Y ☐ N
Babinski	☐ Y ☐ N

Motor	WNL	Grade
C5	☐	0 1 2 3 4 5/**5**
C6	☐	0 1 2 3 4 5/**5**
C7	☐	0 1 2 3 4 5/**5**
C8	☐	0 1 2 3 4 5/**5**
T1	☐	0 1 2 3 4 5/**5**
L1	☐	0 1 2 3 4 5/**5**
L2	☐	0 1 2 3 4 5/**5**
L3	☐	0 1 2 3 4 5/**5**
L4	☐	0 1 2 3 4 5/**5**
L5	☐	0 1 2 3 4 5/**5**
S1	☐	0 1 2 3 4 5/**5**

DTR	+2/4	Deficit
C5	☐	0 1 3 4
C6	☐	0 1 3 4
C7	☐	0 1 3 4
L4	☐	0 1 3 4
L5	☐	0 1 3 4
S1	☐	0 1 3 4

Sensory	WNL	Absent	Hypo
C5	☐	☐	☐
C6	☐	☐	☐
C7	☐	☐	☐
C8	☐	☐	☐
T1	☐	☐	☐
L1	☐	☐	☐
L2	☐	☐	☐
L3	☐	☐	☐
L4	☐	☐	☐
L5	☐	☐	☐
S1	☐	☐	☐

MUSCULOSKELETAL

Tone	Location
Hypertonic w Associated TrP's	☐ **Csp psm** B R L ☐ **CTsp psm** B R L ☐ **Tsp psm** B R L ☐ **TLsp psm** B R L ☐ **Lsp psm** B R L ☐ **Lumbosacral psm** B R L ☐ **Suboccipitals** B R L ☐ **SCM** B R L ☐ **Scalenes** B R L ☐ **UTs** B R L ☐ **UTs/Mid Traps** B R L ☐ **Lev Scap** B R L ☐ **Sh Girdle** B R L ☐ **Rot Cuff** B R L ☐ **Rhom** B R L ☐ **Intercostals** B R L ☐ **Lat Dorsi** B R L ☐ **QL** B R L *Other:* ☐ **Glut med/min** B R L ☐ **Piriformis** B R L ☐ **Iliopsoas** B R L ☐ **Hip mm's** B R L ☐ **TFL/ITB** B R L ☐ **Arm /wrist/hand** B R L ☐ **Quads** B R L ☐ **Hams** B R L ☐ **Gastroc/sol** B R L ☐ **Foot ankle** B R L
Tone	**Location**
Spasms	☐ **Csp psm** B R L ☐ **CTsp psm** B R L ☐ **Tsp psm** B R L ☐ **TLsp psm** B R L ☐ **Lsp psm** B R L ☐ **Lumbosacral psm** B R L ☐ **Suboccipitals** B R L ☐ **SCM** B R L ☐ **Scalenes** B R L ☐ **UTs** B R L ☐ **UTs/Mid Traps** B R L ☐ **Lev Scap** B R L ☐ **Sh Girdle** B R L ☐ **Rot Cuff** B R L ☐ **Rhom** B R L ☐ **Intercostals** B R L ☐ **Lat Dorsi** B R L ☐ **QL** B R L *Other:* ☐ **Glut med/min** B R L ☐ **Piriformis** B R L ☐ **Iliopsoas** B R L ☐ **Hip mm's** B R L ☐ **TFL/ITB** B R L ☐ **Arm /wrist/hand** B R L ☐ **Quads** B R L ☐ **Hams** B R L ☐ **Gastroc/sol** B R L ☐ **Foot ankle** B R L
Tone	**Location**
Tight	☐ **Csp psm** B R L ☐ **CTsp psm** B R L ☐ **Tsp psm** B R L ☐ **TLsp psm** B R L ☐ **Lsp psm** B R L ☐ **Lumbosacral psm** B R L ☐ **Suboccipitals** B R L ☐ **SCM** B R L ☐ **Scalenes** B R L ☐ **UTs** B R L ☐ **UTs/Mid Traps** B R L ☐ **Lev Scap** B R L ☐ **Sh Girdle** B R L ☐ **Rot Cuff** B R L ☐ **Rhom** B R L ☐ **Intercostals** B R L ☐ **Lat Dorsi** B R L ☐ **QL** B R L *Other:* ☐ **Glut med/min** B R L ☐ **Piriformis** B R L ☐ **Iliopsoas** B R L ☐ **Hip mm's** B R L ☐ **TFL/ITB** B R L ☐ **Arm /wrist/hand** B R L ☐ **Quads** B R L ☐ **Hams** B R L ☐ **Gastroc/sol** B R L ☐ **Foot ankle** B R L
Tone	**Location**
Hypotonic	☐ **Csp psm** B R L ☐ **CTsp psm** B R L ☐ **Tsp psm** B R L ☐ **TLsp psm** B R L ☐ **Lsp psm** B R L ☐ **Lumbosacral psm** B R L ☐ **Suboccipitals** B R L ☐ **SCM** B R L ☐ **Scalenes** B R L ☐ **UTs** B R L ☐ **UTs/Mid Traps** B R L ☐ **Lev Scap** B R L ☐ **Sh Girdle** B R L ☐ **Rot Cuff** B R L ☐ **Rhom** B R L ☐ **Intercostals** B R L ☐ **Lat Dorsi** B R L ☐ **QL** B R L *Other:* ☐ **Glut med/min** B R L ☐ **Piriformis** B R L ☐ **Iliopsoas** B R L ☐ **Hip mm's** B R L ☐ **TFL/ITB** B R L ☐ **Arm /wrist/hand** B R L ☐ **Quads** B R L ☐ **Hams** B R L ☐ **Gastroc/sol** B R L ☐ **Foot ankle** B R L

SEGMENTAL JOINT DYSFUNCTION

C0/1	C2	C3	C4	C5	C6	C7	T1	T2	T3	T4	T5	T6	T7	T8	T9	T10	T11	T12	L1	L2	L3	L4	L5
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
S1	**S2**	**S3**	**S4**	**S5**																			
☐	☐	☐	☐	☐																			

Pelvic Listings		Extremities/Extraspinal	
Left Ilium	☐ PI ☐ AS ☐ PI-IN ☐ PI-EX	☐ **Shoulder** R L	☐ **Ribs** R L levels?
Right ilium	☐ PI ☐ AS ☐ PI-IN ☐ PI-EX	☐ **Elbow** R L	☐ **Hip** R L
Sacral Apex	☐ SAR ☐ SAL	☐ **Wrist** R L	☐ **Knee** R L
Sacral Base	☐ Nutation ☐ Counternutation ☐ Right tilt ☐ Left Tilt	☐ **Hand** R L	☐ **Ankle** R L
Coccyx	☐ Right ☐ Left	☐ **Fingers** R L	☐ **Foot** R L

DDX: Go to Chirotouch to find & enter diagnosis.

TREATMENT FREQ: ☐1 ☐2 ☐3 ☐4 ☐5 **Treatments per week for** ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 **Weeks, Re-evaluation due!**

CHIROPRACTIC TECHNIQUE

Sigma	☐ **FS/Pelvis** ☐ **Csp** ☐ **Tsp** ☐ **Lsp** ☐ **SI** B R L ☐ **Sacrum** ☐ **Ribs** B R L ☐ **UE** B R L sh elb wr hand ☐ **LE** B R L hip knee ankle foot
Activator	☐ **FS/Pelvis** ☐ **Csp** ☐ **Tsp** ☐ **Lsp** ☐ **SI** B R L ☐ **Sacrum** ☐ **Ribs** B R L ☐ **UE** B R L sh elb wr hand ☐ **LE** B R L hip knee ankle foot
Arthrostim	☐ **FS/Pelvis** ☐ **Csp** ☐ **Tsp** ☐ **Lsp** ☐ **SI** B R L ☐ **Sacrum** ☐ **Ribs** B R L ☐ **UE** B R L sh elb wr hand ☐ **LE** B R L hip knee ankle foot
Flexion/Distraction	☐ **Lsp**
Diversified	☐ **FS/Pelvis** ☐ **Csp** ☐ **Tsp** ☐ **Lsp** ☐ **SI** B R L ☐ **Sacrum** ☐ **Ribs** B R L ☐ **UE** B R L sh elb wr hand ☐ **LE** B R L hip knee ankle foot
Pelvic Drop	☐ **Pelvis** ☐ **SI** B R L
Other:	

ANCILLARY THERAPIES

Massage Therapy	☐ **FS/Pelvis** ☐ **Csp** ☐ **Tsp** ☐ **Lsp** ☐ **Pelv** B R L ☐ **Sacrum** ☐ **Ribs** B R L ☐ **UE** B R L sh elb wr hnd ☐ **LE** B R L hip kn ank ft
STRETCH	☐ **FS/Pelvis** ☐ **Csp** ☐ **Tsp** ☐ **Lsp** ☐ **Pelv** B R L ☐ **Sacrum** ☐ **Ribs** B R L ☐ **UE** B R L sh elb wr hnd ☐ **LE** B R L hip kn ank ft
☐ **Ice** ☐ **HMP**	☐ **Csp/CTsp** ☐ **Tsp/TLsp** ☐ **Lsp/LS** ☐ **SI** B R L ☐ **Sacrum** ☐ **Ribs** B R L ☐ **UE** B R L sh elb wr hnd ☐ **LE** B R L hip kn ank ft
IFC	☐ **Csp/CTsp** ☐ **Tsp/TLsp** ☐ **Lsp/LS** ☐ **SI** B R L ☐ **Sacrum** ☐ **Ribs** B R L ☐ **UE** B R L sh elb wr hnd ☐ **LE** B R L hip kn ank ft
LLLT	☐ **Csp/CTsp** ☐ **Tsp/TLsp** ☐ **Lsp/LS** ☐ **SI** B R L ☐ **Sacrum** ☐ **Ribs** B R L ☐ **UE** B R L sh elb wr hnd ☐ **LE** B R L hip kn ank ft
NSSD	☐ **Csp** ☐ **Lsp** **Max:____lbs Min:_____ lbs. for ____Minutes**
Other:	

DC: _____ Scribe initials: ____

Health 1st First REHAB INC.

Home Care Instructions for: _____

Date: _____

- To assist with your healing process, only perform instructions checked specifically for your condition.
- Perform all home instruction/exercises to your tolerance and ability.
- If your symptoms worsen, discontinue and contact your chiropractic physician.

Ice / Heat Therapy:

☐ **ICE ONLY:** Apply ice pack for **20** minutes every **2** hours. (*Avoid placing ice pack directly on skin*)

☐ **ICE CUP:** Use ice cup directly on injured area **6** minutes every **2** hours. (*Use circular motion*)

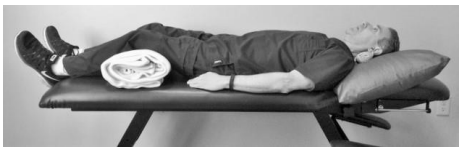
☑ **ALTERNATE HEAT AND ICE:** Shower for **5 -10** minutes, follow immediately with ice pack for **20** minutes. Can use moist heat pack if a shower is not available.

☐ **HEAT ONLY:** Apply hot moist pack for **20** minutes every **2** hour(s) or as needed.

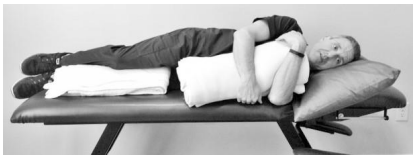
☐ **EPSOM SALT BATH:** Soak for **10** minutes. Repeat 2-3 times per day or as needed. Follow immediately with ice pack or **20** minutes.

Positions of Rest: ***AVOID:*** Sitting, Lifting, Bending, Twisting, Prolonged Standing and Sleeping on Stomach.

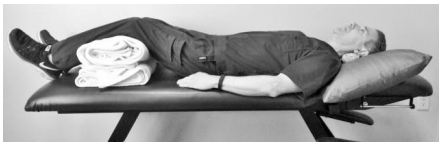
☑ Sleep on your back with a pillow(s) under knees.



☑ Sleep on your ___ side, with a pillow between your knees and ñug a pillowòor use a body pillow.

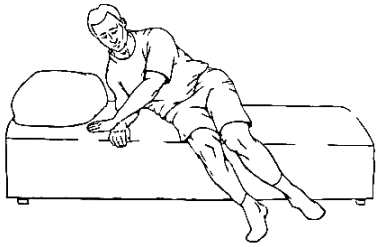


☑ Rest/Ice on your back with two pillows under your knees.



Arising From Bed:

1. **Start from a side lying position**.
2. Maintain control of your legs as you swing them off the edge of the bed, **use your elbow/arms to sit upright.**
3. **Exhale as you move from** a lying to seated position. *Don't hold your breath!*



Additional Instructions:

☑ ***Drink plenty of water!*** Water is important for many reasons and it helps with your healing process.

☑ Use **Valerian Root** (homeopathic muscle relaxant) to help you sleep if needed. Take 1 -2 capsules, ½ hour before bed. Available at local drug stores and natural food stores.

☑ Apply **BioFreeze** as needed.

☐ Source of Life ☐ Disc Flex ☐ AI Formula

☐ Magnesium glyincate 400-500mg/day to bowel tolerance

☐