



Please circle on the diagram the location where you have pain.

Circle what best describes your pain quality: Sharp, Dull, Burning, Stabbing, Ache

Since your last visit is your pain: Getting better, Getting worse, About the same?

S: What is the reason (chief complaint) for your visit today?

Please place a slash mark along the line to show how intense your pain is today.

Mild Annoying Distracting Can't Ignore Can't Sleep Limits Activity Nauseous Passed Out

Circle if experiencing: Tenderness / Muscle Spasms / Weakness / Tingling / Numbness / Stiffness

What aggravates it? (Makes it worse) _____

What relieves it? (Makes it better) _____

Have you had a new injury since your last treatment? Yes or No. Please describe _____

Signature _____ Date _____

=====DO NOT WRITE BELOW THIS LINE=====

Section 2

Chief Complaint: (See above) _____

Subluxation demonstrated By: Exam / X-ray Date: _____

O: Asymmetry / Misalignment: C/S T/S L/S

C/S 1 2 3 4 5 6 7 **T/S** 1 2 3 4 5 6 7 8 9 10 11 12 **L/S** 1 2 3 4 5 LSI RSI SA

Pain/Tenderness: C/S T/S L/S LSI RSI SA

Range Of Motion Abnormality: C/S T/S L/S LSI RSI SA

Tone/Tissue Change:

- Hypertonicity: C/S T/S L/S LSI RSI SA
- Myospasms: C/S T/S L/S LSI RSI SA
- Tender to Touch: C/S T/S L/S LSI RSI SA
- Trigger Points: C/S T/S L/S LSI RSI SA
- Inflammation: C/S T/S L/S LSI RSI SA

A: Changes since last visit: Better Worse Same New

Other: _____

P: Adjust/Treatment: Manual Manipulation / Manual Device

C/S 1 2 3 4 5 6 7 **T/S** 1 2 3 4 5 6 7 8 9 10 11 12 **L/S** 1 2 3 4 5 LSI RSI SA

Progress in treatment: New condition - slower / faster than expected

Evaluation of effectiveness:

Progress noted in: ROM VAS ADL Orthopedic tests Treatment goals

Condition is: New, Improving, Worsening, Early in treatment, Same

Treatment Goals: Return to work, Recreational activities, Household activities, Increase sitting tolerance, Increase standing tolerance, Decrease pain, Able to sleep full night, Other: _____

DX: 739.1 739.2 739.3 739.4 739.5 Other _____

Treatment performed without incident Y / N _____

Dr. Signature: _____ **Date:** _____

ABN Needed: Y / N **Reason:** _____

CERVICAL ROM				CERVICAL ORTHO	
Norm	Exam	Pain	Loc	L / R	
Flex 60	/	/	/	Max C/S Comp	/
Ext 50	/	/	/	C- Dist	/
R. Flex 45	/	/	/	Sh. Dep.	/
L. Flex 45	/	/	/	Shepelman	/
R. Rot 80	/	/	/	T/S Comp	/
L. Rot 80	/	/	/		

LUMBAR ROM				LUMBAR ORTHO	
Norm	Exam	Pain	Loc	L / R	
Flex 90	/	/	/	Laseque	/
Ext. 50	/	/	/	Braggard	/
R. Flex 25	/	/	/	Fabere	/
L. Flex 25	/	/	/	Kemp	/
R. Rot 30	/	/	/	Valsalva	/
L. Rot 30	/	/	/	Ely's	/
				Hibbs	/
				Yoemans	/

Therapies	C/S	T/S	L/S	Other	Min.
Heat/Ice					
EMS					
Traction					
US					
Other					
Ther.Ex.					
NMR					
MFR					
Massage					

Performed by: _____

ABN Signed: Y / N