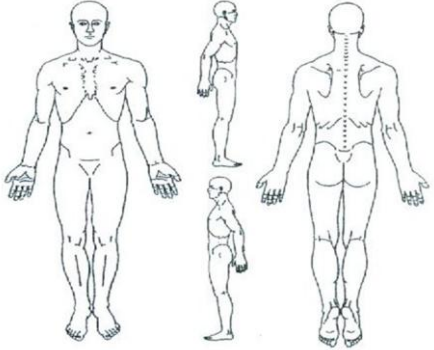


Print **Patient Name:** _____ **Date:** _____

PAIN LEVEL					PAIN FREQUENCY				PAIN TYPE										
No Pain	Mild	Moderate	Severe	Unbearable	1 = Intermittent (0 - 25%)		2 = Occasional (26% - 50%)		SHARP	DULL	ACHY	BURNING	THROBBING						
0	1	2	3	4	5	6	7	8	9	10	3 = Frequent (51% - 75%)		4 = Constant (76% - 100%)		STIFF	SHOOTING	TINGLING	NUMBNESS	OTHER
Area of Injury / Pain					Pain Level	Pain Frequency	Pain Type												
1. _____					_____/10	_____	_____												
2. _____					_____/10	_____	_____												
3. _____					_____/10	_____	_____												
4. _____					_____/10	_____	_____												
5. _____					_____/10	_____	_____												
6. _____					_____/10	_____	_____												

Signing below indicates the above information is correct and gives the doctor permission to treat my condition as deemed necessary.

Patient Signature: _____ **Date:** _____ **Staff:** _____

..... PLEASE DO NOT WRITE BELOW THE DOTTED LINE

Ice / Heat.....97010 Area R L B C UT MT L SI Extremity:	Acupuncture.....97810 Area / Points:	<input type="checkbox"/> Cervical Decompression Traction.....97012 <input type="checkbox"/> Lumbar Decompression Traction.....97012 Pounds: _____ <u>Time</u> 10 12 15
<input type="checkbox"/> Interferential97014 <input type="checkbox"/> EMS.....97014 Area R L B C UT MT L SI Extremity:	<u>Time</u> 10 12 15 Contract.	<input type="checkbox"/> Acute <input type="checkbox"/> Sub acute <input type="checkbox"/> Muscle <input type="checkbox"/> Chronic <input type="checkbox"/> 80 - 120 <input type="checkbox"/> 1 - 150 <input type="checkbox"/> 3 - 5 <input type="checkbox"/> 50 <input type="checkbox"/> Fitball 97112 <input type="checkbox"/> Floor <input type="checkbox"/> Wobble Board <u>Time</u> 8 10 12 15
Rehab Exercises.....97110 Area R L B C UT MT L SI Extremity: R L B	<u>Time</u> IN: OUT:	Necksys: Level 1 2 3 4 5 6 Sets: 1 2 3 Reps: 6 Strength <input type="checkbox"/> Yellow <input type="checkbox"/> Red <input type="checkbox"/> Green <input type="checkbox"/> Blue Sets: 1 2 3 Reps: 6 10 12
Comments: (see pt. chart for specific exercise) Staff:		

Rehab Exercises performed to: Decrease Pain Increase Range of Motion Increase Flexibility Increase Muscular Strength
 Increase Cardiovascular Endurance Improve Balance and Proprioception

Patient Complying with Home Therapy/Exercise: Yes No

Patient Assessment: Progressing as expected / Slower than expected Exacerbation Unchanged Worse
 Other/Explanation _____

Today's Procedures: 1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____

Objective Findings: Subluxation Levels and Area(s) of Manipulation: All Manipulations were performed using Diversified technique unless noted

Occ	C1	2	3	4	5	6	7	T1	2	3	4	5	6	7	8	9	10	11	12	L1	2	3	4	5	Sac	RSI	LSI	Extremities

Ranges of Motion: _____

Ortho Tests: _____

Palpation: Spasm _____ **Hyper tonicity** _____ **Tenderness** _____

Neuro: DTR _____ **Sensation** _____ **Muscle Test** _____

Re-Schedule _____ Provider Signature _____ Date _____