Name:
Date:

Welcome to Our Office!

Patient Information

Home Phone #: _____

Cell Phone #: _____

Employer Name: _____

Occupation: _____

Employer Phone #: _____

Marital Status: Married Single Widowed Divorced
(Please Circle One)

Significant Other: _____

Phone #: _____

Social Security #: _____

Date of Birth: _____

Number of Children: _____

Emergency Contact: _____
(Not necessary if it is your significant other)

Relationship: _____
(Not necessary if it is your significant other)

Phone #: _____
(Not necessary if it is your significant other)

Primary Care Provider (PCP)

Name: _____

Phone #: _____

Why are you here today? Chief Complaint

_____

Have you ever been to a chiropractor? Y / N

If yes, when was your last adjustment? _____

How were you referred? _____

Do you have VA benefits? Y / N

Do you have AFLAC benefits? Y / N

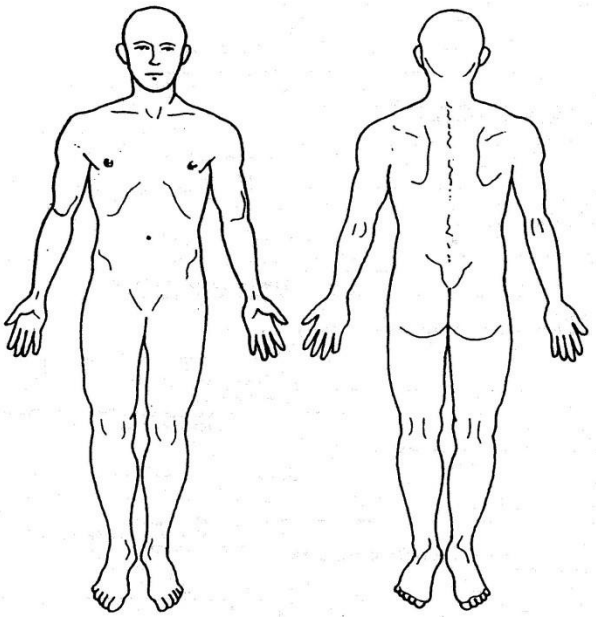
Do you have an HSA/FSA or Benflex card? Y / N

Name:
Date:

Condition Information

Mark the areas on your body where you feel your discomfort. Include all affected areas of radiation. If your discomfort radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as it travels. Use the appropriate symbol(s) listed below.

Ache > > > >	Numbness = = = =	Pins & Needles o o o o
Burning x x x x	Stabbing / / / /	Throbbing ~ ~ ~ ~



When did the condition begin? _____

Has it ever happened before? _____

Have you seen any other doctor for this condition? _____

If yes, when was your last treatment? _____

Is the condition:

___A Result of a Motor Vehicle Accident
MVA Claim Number: _____
___A Result of a Worker's Compensation Injury
WC Claim Number: _____
___Other Injury
___No Injury

Quadruple Visual Analogue Scale

1. What is your pain RIGHT NOW?

no pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

no pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

no pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

no pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

Office Use Only: #1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 = _____ (Low intensity = <50; High intensity = >50)

Name:
Date:

Review of Systems

Below is a list of diseases, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Please fill out all sections, even if "None".

Constitutional:	☐ Chills	☐ Daytime Sleepiness	☐ Fatigue	☐ Fever	☐ Night Sweats
☐ None	☐ Weight Gain	☐ Weight Loss			
Eyes/Vision:	☐ Blindness	☐ Blurred Vision	☐ Cataracts	☐ Change in Vision	☐ Double Vision
☐ None	☐ Eye Pain	☐ Field Cuts	☐ Glasses/Contacts	☐ Glaucoma	☐ Itching
☐ Photophobia	☐ Tearing				
ENT:	☐ Bleeding	☐ Dentures	☐ Difficulty Swallowing	☐ Discharge	☐ Dizziness
☐ None	☐ Ear Drainage	☐ Ear Pain	☐ Fainting	☐ Frequent Sore Throats	☐ Headaches
☐ Hearing Loss	☐ History of Head Injury	☐ Hoarseness	☐ Loss of Smell	☐ Nasal Congestion	☐ Nose Bleeds
☐ Post Nasal Drip (PND)	☐ Rhinorrhea (Runny Nose)	☐ Sinus Infections	☐ Snoring	☐ Tinnitus (Ringing in Ear)	☐ TMJ
Respiration:	☐ Asthma	☐ Cough	☐ Coughing up Blood	☐ Shortness of Breath (SOB)	☐ Sputum Production
☐ None	☐ Wheezing				
Cardio:	☐ Angina	☐ Chest Pain	☐ Claudication	☐ Heart Murmur	☐ Heart Problems
☐ None	☐ Orthopnea	☐ Palpitations	☐ PND	☐ SOB with Exertion	☐ Swelling of Legs
☐ Varicose Veins					
Gastro:	☐ Abdominal Pain	☐ Belching	☐ Black Tarry Stools	☐ Constipation	☐ Diarrhea
☐ None	☐ Difficulty Swallowing	☐ Heartburn	☐ Hemorrhoids	☐ Indigestion	☐ Jaundice
☐ Nausea	☐ Rectal Bleeding	☐ Regurgitation	☐ Ulcer	☐ Change in Stool Color	☐ Stool Consistency
☐ Vomiting	☐ Vomiting Blood				
Female:	☐ Breast Lumps/Pain	☐ Burning Urination	☐ Cramps	☐ Frequent Urination	☐ Irregular Menstruation
☐ None	☐ Urine Retention	☐ Vaginal Bleeding	☐ Vaginal Discharge		
Male:	☐ Burning Urination	☐ Erectile Dysfunction	☐ Frequent Urination	☐ Hesitancy/Dribbling	☐ Prostate
☐ None	☐ Urine Retention				
Endocrine:	☐ Cold Intolerance	☐ Diabetes	☐ Excessive Appetite	☐ Excessive Hunger	☐ Excessive Thirst
☐ None	☐ Frequent Urination	☐ Goiter	☐ Hair Loss	☐ Heat Intolerance	☐ Unusual Hair Growth
☐ Voice Changes					
Skin:	☐ Changes in Nail Texture	☐ Changes in Skin Color	☐ Hair Growth	☐ Hair Loss	☐ History of Skin Disorders
☐ None	☐ Hives	☐ Itching	☐ Paresthesia	☐ Pruritis	☐ Rash
☐ Skin Lesions/Ulcers	☐ Varicosities				
Nervous:	☐ Dizziness	☐ Facial Weakness	☐ Headache	☐ Limb Weakness	☐ Loss of Consciousness
☐ None	☐ Loss of Memory	☐ Numbness	☐ Seizures	☐ Sleep Disturbance	☐ Slurred Speech
☐ Stress	☐ Strokes	☐ Tremor	☐ Unsteadiness of Gait		
Psychological:	☐ Anhedonia	☐ Anxiety	☐ Appetite	☐ Behavioral Change	☐ Bipolar
☐ None	☐ Confusion	☐ Depression	☐ Insomnia	☐ Memory Loss	☐ Mood Change
Allergy:	☐ Anaphylaxis	☐ Food Intolerance	☐ Itching	☐ Nasal Congestion	☐ Sneezing
☐ None					
Hematology:	☐ Anemia	☐ Bleeding	☐ Blood Clotting	☐ Blood Transfusions	☐ Bruising
☐ None	☐ Fatigue	☐ Lymph Node Swelling			

Name:
Date:

Past Health History

Please fill out the information below carefully as these problems could affect your overall course of treatment.

Childhood Illnesses:	☐ ADD	☐ Allergies/Hay fever	☐ Asthma	☐ Atopic Dermatitis	☐ Cerebral Palsy
☐ None	☐ Depression	☐ Diabetes	☐ Fetal Drug Exposure	☐ Food Allergies	☐ Headaches
☐ Measles	☐ Mumps	☐ Rash	☐ Seizure Disorder	☐ Sickle Cell Anemia	☐ Unusual Childhood Illness
Adult Illnesses:	☐ Anemia	☐ Arthritis	☐ Asthma	☐ Cancer	☐ Chicken Pox
☐ None	☐ CVA (Stroke)	☐ Depression	☐ Diabetes (Insulin Dep)	☐ Diabetes (NIDDM)	☐ Eye Problems
☐ Hepatitis	☐ Hypertension	☐ Kidney Disease	☐ Liver Disease	☐ Lung Disease	☐ Seizures
☐ Similar Symptoms	☐ STD's	☐ Suicide Attempts	☐ Thyroid Problem		
Surgeries:	☐ Angioplasty	☐ Appendectomy	☐ Caesarean Section	☐ Cardiac Catheterization	☐ Carpal Tunnel Release
☐ None	☐ Cosmetic	☐ D&C	☐ Hemorrhoidectomy	☐ Hernia Repair	☐ Hysterectomy
☐ Joint Replacement	☐ Laminectomy	☐ Mastectomy	☐ Pacemaker Insertion	☐ Spinal Fusion	☐ Gallbladder

☐ Other(s): _____

To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or present? Yes No (Please Circle One)

If yes, please explain: _____

Are there any other conditions we should know about, even if unrelated? _____

Have you had any previous: X-ray MRI CT (please circle) Other _____

Have you had previous Chiropractic care before? Yes No (Please Circle One)

If yes, when was your last treatment? _____

Has anyone else in your family experienced this condition? Yes No (Please Circle One)

Social History

Alcohol:	☐ None	☐ Beer	☐ Liquor	☐ Social Consumption
Diet:	☐ High Fat Diet	☐ High Fiber	☐ High Protein	☐ High Salt Intake
	☐ Low Calorie Intake	☐ Low Carbohydrate	☐ Low Fiber	☐ Low Salt

Education: ☐ Level or Degree Attained: _____

Substance: ☐ Denies Any ☐ Denies IV Drugs Not Used Since: _____

Tobacco: Type(s): _____

WOMEN ONLY:

Are you pregnant or is there any possibility that you may be pregnant?

Yes No Uncertain N/A (Please Circle One)

Name:
Date:

Health Information Consent Form

We want you to know how your Protected Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Protected Health Information will be used and I agree to these policies and procedures.

_____ _____

Patient/Guardian Signature Date

Name:
Date:

Office Financial Policy

We would like to thank you for choosing Iadeluca Chiropractic Center. We are committed to providing you with the best possible care. If you have medical insurance, we wish to help you receive your maximum allowable benefits. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal.

Payment

Payment is required at the time of service. This includes applicable co-payments, coinsurance, deductible and processing fees. We accept cash, check, credit card and CareCredit. We also offer flexible monthly payment plans. We charge a fee for checks returned for insufficient funds.

Insurance

Please remember insurance plans vary considerably and we cannot predict or guarantee what part of our services will or will not be covered. We make our best effort to see that your benefits are verified with your insurance on your first visit with our office. It is the responsibility of the **patient** to provide accurate and timely insurance information. Inaccurate or untimely information given to us that result in denial or non-coverage may leave you responsible for payment. It is your responsibility to keep us informed of any changes communicated to you by your insurance company. Patients are ultimately responsible for knowledge of specific coverage guidelines and requirements pertaining to their individual plan. For example, if your plan only allows 15 chiropractic visits and you exceed that limit, you are financially responsible for payment of the additional visits.

- If we do not participate with your insurance, we are not able to bill your insurance and we cannot accept payment from them. We will provide you with an itemized bill so that you may submit the charges for reimbursement.
- We do not bill secondary insurance companies. It will be your responsibility to file any remaining balances left from your primary insurance company.
- We will bill Medicare but you are responsible for payment of applicable deductible, coinsurance and non-covered services.
- Not all services are a covered benefit for all insurance plans. In the event that your health plan determines a service to be "not covered", you will be responsible for the charge.
- Keep in touch: Do not assume your insurance carrier is "working on it". Contact them if you have not received notice of payment within 30 to 45 days of your services. If payment is delayed by your health plan, you will be asked to contact them to rectify any issues.

Acknowledgement

I have read and understand the financial policy. I understand that my insurance contract is an arrangement between **myself and my insurance company, NOT between Iadeluca Chiropractic Center and my insurance company.** I request that Iadeluca Chiropractic Center prepare the customary forms at no charge so that I may obtain insurance benefits.

_____ _____

Patient/Guardian Signature Date

Name:
Date:

Office Financial Policy

Collections and Past Due Accounts

Each delinquent statement will have a $5.00 fee added to the current balance of your account. There will be a surcharge to any account that is sent to collections of $50.00 or 5%, whichever is greater.
In the case of a dispute where Iadeluca Chiropractic Center prevails, the patient agrees to reimburse Dr. Iadeluca for lost time for court hearings or depositions. Reasonable attorney fees incurred in such an action will also be reimbursed by the patient.

I understand if I have an unpaid balance to IADELUCA CHIROPRACTIC CENTER and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of the fee of any collection agency, which may be based on percentage at a maximum of 50% of the debt, and all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts.

In order for IADELUCA CHIROPRACTIC CENTER or their designated external collection agency to service my account and where not prohibited by applicable law, I agree that IADELUCA CHIROPRACTIC CENTER and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing service, as applicable. Furthermore, I consent the designated external collection agency to share personal contact and account related information with third party vendors to communicate account related information via telephone, text, e-mail and mail notification.

_____ _____

Patient/Guardian Signature Date

Name:
Date:

E-Mail Billing Statement Consent

Patient billing statements are now available through the convenience of email. We require your consent to begin using this service to communicate with you. Our office will use reasonable means to protect the security and confidentiality of the information sent and received. However, because of the risks associated with email communication, we cannot guarantee the security and confidentiality of the message and will not be liable for improper disclosure of confidential information that may be improperly disclosed.

Preferred Email Address: _____

Text Message Reminder Consent

Patient visit reminders will soon be available via text messaging. If you'd prefer this method of reminder over a phone call, please fill in the information below. We require your consent to begin using this service to communicate with you. Our office will use reasonable means to protect the security and confidentiality of the information sent and received. However, because of the risks associated with text messaging, we cannot guarantee the security and confidentiality of the message and will not be liable for improper disclosure of confidential information that may be improperly disclosed.

Preferred Cell Phone #: _____

Cell Phone Carrier: _____

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication through e-mail and text messaging between the Provider and myself, and consent to the conditions herein. Any questions I may have had were answered.

_____ _____

Patient/Guardian Signature Date

Name:
Date:

VITALS		REFLEXES		DERMATOMES	DYNAMOMETER		
Weight	#	☐ Upper +2 (C5-8)		☐ Upper Equal		L	R
Height	' "	☐ Lower +2 (L2-S2)		☐ Lower Equal	1		
BP	/	Biceps	Patella	C5 C6 C7 C8	2		
Pulse	BPM	Brachio	Achilles	T1 T2 L1 L2	3		
Respir	BPM	Triceps		L3 L4 L5 S1	MS		
Temp	☐ NTT			Hypo Hyper	☐ U Ext +5 _____		
Pref Side	L R	PCP:			☐ L Ext +5 _____		

ORTHO CERVICAL TESTS:									
Tenderness				Increase MS Tone	(Mild Mod Sev)				
Cerv Reg	L	R	Both	Cerv region	L	R	Both	1	2	3
C1	L	R	Both	Trapezius	L	R	Both	1	2	3
SP	C1 C2 C3 C4			Scalenus	L	R	Both	1	2	3
	C5 C6 C7			SCM	L	R	Both	1	2	3
				Sub Occipital	L	R	Both	1	2	3
ROM				Myofascial TP						
☐ Decreased				Trapezius	L	R	Both	1	2	3
☐ Painful				Scalenus	L	R	Both	1	2	3
☐ Increased**				SCM	L	R	Both	1	2	3
				Sub Occipital	L	R	Both	1	2	3
				Levator Scap	L	R	Both	1	2	3

ORTHO THORACIC SPINE TESTS:									
Tenderness				Increase MS Tone	(Mild Mod Sev)				
Thor Reg	L	R	Both	Thor Reg	L	R	Both	1	2	3
Costo Jts	L	R	Both	Erector SP	L	R	Both	1	2	3
Costo Vert	L	R	Both	Trapez	L	R	Both	1	2	3
SP	T1 2 3 4			Levator	L	R	Both	1	2	3
	T5 6 7 8			Rhomb	L	R	Both	1	2	3
	T9 10 11 12			Myofascial TP						
ROM				Erector SP	L	R	Both	1	2	3
☐ Decreased				Trapez	L	R	Both	1	2	3
☐ Painful				Levator	L	R	Both	1	2	3
☐ Increased**				Rhomb	L	R	Both	1	2	3

LUMBAR TESTS:									
Tenderness				Increase MS Tone	(Mild Mod Sev)				
Lumbar Reg	L	R	Both	Lumbar Region	L	R	Both	1	2	3
Erector SP	L	R	Both	Erector Region	L	R	Both	1	2	3
Quad Lumb	L	R	Both	Quad Lumb	L	R	Both	1	2	3
SP	L1 2 3 4			Iliocostalis	L	R	Both	1	2	3
	L5 S1			Myofascial TP						
ROM				Erector SP	L	R	Both	1	2	3
☐ Decreased				Quad lumb	L	R	Both	1	2	3
☐ Painful				Iliocostailis	L	R	Both	1	2	3
☐ Increased**				Longissimus	L	R	Both	1	2	3

SACROILIAC TESTS:									
Tenderness				Increase MS Tone	(Mild Mod Sev)				
Sacro Tub	L	R	Both	Gluteus	L	R	Both	1	2	3
Sacrolliac	L	R	Both	Pirifor	L	R	Both	1	2	3
Coccyx	L	R	Both	Sacro Tuber	L	R	Both	1	2	3
ROM				Myofascial TP						
☐ Decreased				Gluteus	L	R	Both	1	2	3
☐ Painful				Pirifor	L	R	Both	1	2	3
☐ Increased**				Sacro Tuber	L	R	Both	1	2	3
Pelvis				R L B SI illiopoas	R L B Glut illiopsoas				
Pelvis ROM				☐ Decreased	☐ Painful ☐ Increased				

CERVICAL				
Flex:50				Pain: Mld Mod Sev
Ext:60				Pain: Mld Mod Sev
RLF:45				Pain: Mld Mod Sev
LLF:45				Pain: Mld Mod Sev
R Rot:80				Pain: Mld Mod Sev
L Rot:80				Pain: Mld Mod Sev

THORACIC				
Flex:90				Pain: Mld Mod Sev
Ext:25				Pain: Mld Mod Sev
RLF:25				Pain: Mld Mod Sev
LLF:25				Pain: Mld Mod Sev
R Rot:25				Pain: Mld Mod Sev
L Rot:25				Pain: Mld Mod Sev

LUMBAR				
Flex:60				Pain: Mld Mod Sev
Ext:25				Pain: Mld Mod Sev
RLF:25				Pain: Mld Mod Sev
LLF:25				Pain: Mld Mod Sev
R Rot:45				Pain: Mld Mod Sev
L Rot:45				Pain: Mld Mod Sev

☐ HIP ☐ L ☐ R				☐ SHOULDER ☐ L ☐ R
F:100/180				Pain: Mld Mod Sev
E:20/50				Pain: Mld Mod Sev
Ab:40/180				Pain: Mld Mod Sev
Ad:20/50				Pain: Mld Mod Sev
IR:40/90				Pain: Mld Mod Sev
ER:45/90				Pain: Mld Mod Sev

ORTHOPEDIC TESTING:					
Cerv Val	+ / -	Lumbr Val	+ / -	Dble SLR	+ / -
Maigne	NEG	L Apley	+ / -	R Apley	+ / -
L Bacody	+ / -	R Bacody	+ / -	L Well Leg	+ / -
				R Well Leg	+ / -

L Shldr Dp: loc pain ST ▪ loc pain spsm ▪ loc pain PM s/s ▪ rad

R Shldr Dp: loc pain ST ▪ loc pain spsm ▪ loc pain PM s/s▪ rad

Cerv Distract: neg ▪ relief pain ▪ local pain

Cerv Comp: neg ▪ radic pain ▪ local pain

Extremity: DEC INC ROM, Painful / SIDE: R / L [Hip Shld]

Tender: Inguinal, Ilio, ITB, Crest / Teres, Supra, Infra, Delt, AC, Biceps

Tone: Glut, ITB, HS, Quad, ADD MF: Glut, Piri, TFL (mld,mod/sev)	Tone/MF: Teres, Infra, Supra, Delt, Subscap, Bicep, Pects(mldmodsev)

L Bragg: 65+ ▪ 30-65 ▪ post thigh pain

R Bragg: 65+ ▪ 30-65 ▪ post thigh pain

L SLR: 70+ ▪ 35-70 ▪ post thigh pain

R SLR: 70+ ▪ 35-70 ▪ post thigh pain

L Yeoman's: acute sac ▪ chron loc LBP ▪ acute loc lumb

R Yeoman's: acute sac ▪ chron loc LBP ▪ acute loc lumb

L Lewin Gaenslen: No lord ▪ No SI

R Lewin Gaenslen: No lord ▪ No SI

L Kemps: acute loc sac ▪ chron LBP ▪ acute loc lumbar

R Kemps: acute loc sac ▪ chron LBP ▪ acute loc lumbar

L Patrick: chronic hip ▪ acute hip ▪ Motion restrict

R Patrick: chronic hip ▪ acute hip ▪ Motion restrict

SUB: C1 2 3 4 5 6 7

T1 2 3 4 5 6 7 8 9 10 11 12

L1 2 3 4 5 S PELVIS

Prognosis	Excellent	Fair	Favorable	Good	Guarded	Poor

Name:
Date:

								98940	98941	98942	98943
	HA Head	Neck	Upper Back	Mid Back	Low Back	R Shlder	L Shlder	L hip	R Hip	Other
Location:		L / R Bi	L / R Bi	L / R Bi	L / R Bi					
Severity: 1-5										
Frequency 1-4										
PAIN										

QVAS SCORE	1.	2.	3.	4.
Oswestry	1.	2.	3.	4.
Neck Disability	1.	2.	3.	4.
Shoulder/Hip	1.	2.	3.	4.
Other	1.	2.	3.	4.

Better w/:	☐ Nothing or ☐ Chiropractic				
Worse: HA, Neck, Upper back, Shoulder	☐ Coughing ☐ Prolonged Sitting ☐ Prolonged Walking ☐ Prolonged Standing ☐ Neck Movement ☐ Housework ☐ Deep Breathing ☐ Other _____	☐ Sneezing ☐ Chewing ☐ Extension ☐ Bending ☐ Driving ☐ Pushing ☐ Bright Lights	☐ Lifting ☐ DLA ☐ Pulling ☐ Working ☐ Loud Noises ☐ Reading ☐ Sleep	☐ Rot. Right ☐ Rot. Left ☐ Lying Down ☐ Stand to Lay ☐ Lay to Sit ☐ Lay to Stand ☐ Reaching ☐ Other _____	☐ Sit to Standing ☐ Standing to Sitting ☐ Lat. Flex R ☐ Lat. Flex L ☐ Exercise ☐ Working ☐ Bowel Movements
Worse: Mid back Lower back Hip	☐ Coughing ☐ Prolonged Sitting ☐ Prolonged Walking ☐ Prolonged Standing ☐ Neck Movement ☐ Housework ☐ Deep Breathing ☐ Other _____	☐ Sneezing ☐ Chewing ☐ Extension ☐ Bending ☐ Driving ☐ Pushing ☐ Bright Lights	☐ Lifting ☐ DLA ☐ Pulling ☐ Working ☐ Loud Noises ☐ Reading ☐ Sleep	☐ Rot. Right ☐ Rot. Left ☐ Lying Down ☐ Stand to Lay ☐ Lay to Sit ☐ Lay to Stand ☐ Reaching ☐ Other _____	☐ Sit to Standing ☐ Standing to Sitting ☐ Lat. Flex R ☐ Lat. Flex L ☐ Exercise ☐ Working ☐ Bowel Movements
Quality:	**See QVAS**				
Radiating:	**See QVAS**				
Timing:	☐ Morning ☐ Afternoon ☐ Night ☐ Evening ☐ Light Activities ☐ Mod Activities ☐ Other_____			☐ Morning ☐ Afternoon ☐ Night ☐ Evening ☐ Light Activities ☐ Mod Activities ☐ Other_____	
Side Effects:	☐ Decreased ROM ☐ Increased Sensitivity ☐ Numbness ☐ Stiffness ☐ Tightness ☐ Weakness ☐ Tingling ☐ Other _____			*HA (only):* ☐ Dizziness ☐ Loss of Balance ☐ Nausea ☐ Ring in Ears ☐ Sensitive to Bright Lights ☐ Visual Problems ☐ Other _____	
Vitals:	☐ Minors + / -	☐ Gait + / - L / R		☐ Antalgic L R	
Heel/Toe	☐ Heel Walk / Toe Walk Trendelenburg - negative bilaterally			☐ +_____	

Name:
Date:

Doctor Call Slip

Nickname: _____

Information: _____

Primary Care: _____

Best Phone #: _____

Date of 1st Adjustment: _____

How is the patient doing? _____

_____

_____

AMS: Y / N (all of rx tx plan? Y/N)

# of appointments on TX Plan: _____

Date of next appt: M T W Th F S Date: _____ **Time:** _____

SCC Date: _____ **M T W Th F S Time:** _____

Scheduling CA: _____

Comments: _____

_____

_____

_____

Exam DC: _____

Time of call: _____

Date of call: _____

ROF DC: _____

DC Signature: _____

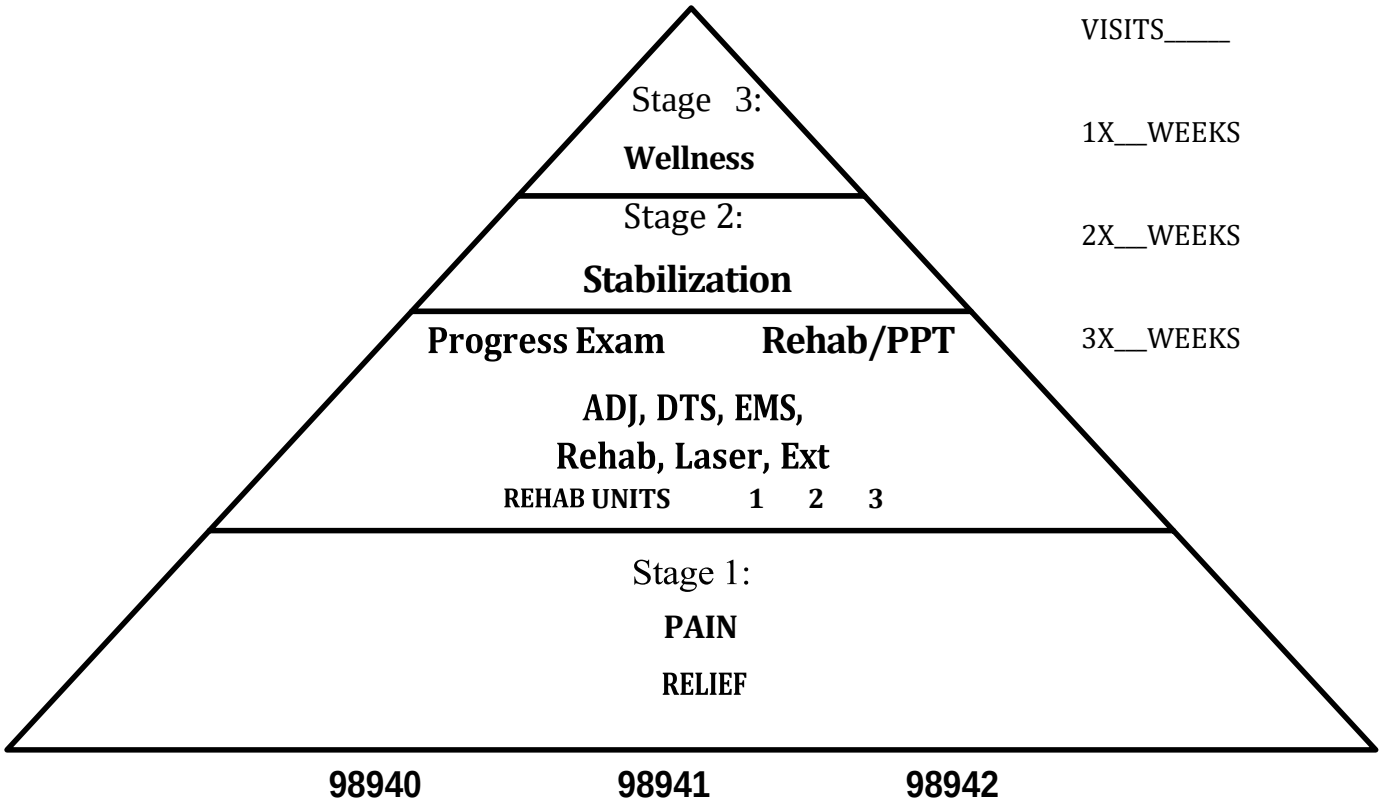
Name:
Date:

Iadeluca chiropractic

WHAT'S THE SOLUTION?

Patients do not all respond the same. Some progress more rapidly than other. While no health provider can guarantee your response to treatment, your recommendations are based on your history, exam and x-ray findings. Should you respond other than expected, your schedule will be altered accordingly.

Your Doctor Recommends:



☐ CBD Topical Max	☐ Ice Pack
☐ CBD Max Relief Oil	☐ TENS
☐ CBD Sleep/Melatonin Oil	☐ Back Max
☐ CBD Gummies	☐ Back Stretcher
☐ Nitrous Oxide	☐ Memory Foam Pillow

_____DC

Name:
Date:

SUBLUX.	M79.10	Myalgia
M99.01 C	**HA's** R51.9	HA, unspecified
M99.02 T	Migraine G43.001	w/o aura, w/o status, control
M99.03 L	Migraine G43.019	w/o auro w/o status, no control
M99.04 S	Migraine G43.109	w/ aura, w/o status, control
M99.05 P	Migraine G43.119	w/ auro, w/o status, no control
M99.06 LE		
M99.07 UE		

CERVICAL DIAGNOSES SHORT TERM	
M47.811	Spondylosis w/o myelopathy C2-C4
M47.812	Spondylosis w/o myelopathy C4-C6
M47.813	Spondylosis w/o myelopathy C6-T1
S16.1XXA	Strain Muscle
M50.31	DD – (C2/4)
M50.321	DD – (C4/5)
M50.322	DD – (C5/6)
M50.323	DD – (C6/7)
M54.12	Radiculopathy

THORACIC DIAGNOSES SHORT TERM	
M47.814	Spondylosis w/o myelopathy or rad., thoracic
M47.815	Spondylosis w/o myelopathy or rad., thoracolumbar
S29.012A	Strain Muscle
M54.6	Pain in thoracic spine
M51.34	Intervert DD – thoracic
M51.35	Intervert DD – thoracolumar
M54.13	Radiculopathy cerv/thor

LONG TERM DIAGNOSES	
CERVICAL M48.32	Trauma-spondylopathy, C-Spine
M48.33	Trauma-spondylopathy, C/T spine
M50.11	DD w/radic – (C2/4)
M50.121	DD w/radic – (C4/5)
M50.122	DD w/radic – (C5/6)
M50.123	DD w/radic – (C6/7)
M50.220	Other cervical disc displacement, mid C
M50.221	Other cervical disc displacement C4-C5
M50.222	Other cervical disc displacement C5-C6
M50.223	Other cervical disc displacement C6-C7
THORACIC M48.34	Trauma spondylopathy, T-Spine
M48.35	Trauma spondylopathy, T/L Spine
M51.14	Intervert DD w/radic - thoracic
M51.15	Intervert DD w/radic – thor/lum
M51.24	Other intervertebral disc displacement, thoracic region
M51.25	Other intervertebral disc displacement, thoracolumbar region
M54.14	Radiculopathy thoracic
M54.15	Radiculopathy thor/lum

Extremity	
M25.551	Pain in R hip
M25.552	Pain in L hip
M77.01	Medial epicondylitis – R elbow
M77.02	Medial epicondylitis – L elbow
M77.11	Lateral epicondylitis – R elbow
M77.12	Lateral epicondylitis – L elbow
M25.511	Pain in R shoulder
M25.512	Pain in L shoulder

COMPLICATING FACTORS (do not number)	
M06.9	Rheumatoid Arthritis unspecified
A.S. M45.X	X = 0 multiple Sites, 1 C0-C1, 2 C, 3 CT, 4 T, 5 TL, 6 L, 7 L/S, 8 Sac, 9 Unspecified
E927.3	Cumulative trauma of repetitive motion
G35	Multiple Sclerosis
M72.2	Plantar fasciitis
F41.8	Anxiety / Depression
M79.7	Fibromyalgia
M62.838	Muscle Spasm
M62.830	Muscle Spasm of the back

Name:
Date:

LUMBAR DIAGNOSES SHORT TERM		**LUMBAR** M48.36	Traumatic spondylopathy, lumbar region	**COMPLICATING FACTORS continued (do not number)**	
M47.816	Spondylosis w/o myelopathy or rad., lumbar	M48.37	Traumatic spondylopathy, lumbosacral region	M62.81	Muscle weakness
M47.817	Spondylosis w/o myelopathy or rad., lumbosacral	M51.26	Other disc displacement, lumbar	R42	Dizziness
M48.061	Spinal stenosis Lumbar region	M51.27	Other disc displacement, lumbosacral	M47.811	Spondy w/o myelopathy C2-C4
S39.012A	Strain Muscle	M51.360	Intervertebral disc degen., lumbar, discogenic back pain only	M47.812	Spondy w/o myelopathy C4-C6
M54.50	Low back pain, unspecified	M51.361	Intervertebral disc degen., lumbar w/extremity pain only	M47.813	Spondy w/o myelopathy C6-T1
M54.51	Vertebrogenic low back pain	M51.362	Intervertebral disc degen, lumbar w/discogenic LBP & extremity pain	M47.816	Spondy w/o myelopathy T12-L3
M54.59	Other low back pain	M51.370	Intervertebral disc degen., lumbosacral, discogenic LBP	M47.817	Spondy w/o myelopathy L3-L5
M54.16	Radiculopathy lumbar	M51.371	Intervertebral disc degen., lumbosacral w/extremity pain	H81.13	Benign Paroxysmal Vertigo
M54.17	Radiculopathy lumboscaral	M51.372	Intervertebral disc degen, lumbosacral w/discogenic LBP & extremity pain	R20.2	Paresthesia of the skin
		M54.31	Sciatica, right side (SI dys)	E66.09	Morbid Obesity
		M54.32	Sciatica, left side (SI dys)	R26.2	Difficulty walking
		M54.41	LBP w/ sciatica RT side (L- Seg DysFn)	R29.3	Abnormal posture
		M54.42	LBP w/ sciatica LT side (L- Seg DysFn)	M81.0	Age related osteoporosis
		M51.16	Intervert DD w/radic - lumbar	M48.02	Spinal Stenosis Cervical region
				M48.062	Spinal stenosis Lumbar region
				E11.9	Type 2 DM w/o complication
				E10.9	Type 1 DM w/o complication
				J44.9	COPD unspecified
				E929.0	Late Effects of MVA

Name:
Date:

MALE/FEMALE

Initial Examination

Acute New: headaches/neck/upper back/mid back/lower back/left hip/right hip/left shoulder/right shoulder _____ (years/months/weeks/days) MVA- Follow the printouts
Chronic New: headaches/neck/upper back/mid back/lower back/left hip/right hip/left shoulder/right shoulder _____ (years/months/weeks/days) but has flared up recently in the last _____ (years/months/weeks/days)
Chronic N2: headaches/neck/upper back/mid back/lower back/left hip/right hip/left shoulder/right shoulder _____ (years/months/weeks/days) that has progressively worsened

Re-examination

_____Re-exam Slow
_____Re-exam Well (Going well)
_____Re-exam Well 2 (Residual)
_____Re-exam Well 3 (MMI)

Reactivation

Past for: headaches/neck/upper back/mid back/lower back/left hip/right hip/left shoulder/right shoulder
Now for: headaches/neck/upper back/mid back/lower back/left hip/right hip/left shoulder/right shoulder _____ (years/months/weeks)

S.M.A.R.T Goals

1. Reduce worst pain levels from _____to _____by next evaluation (6 visits)
2. Patient's (NDI/Oswestries/Extremity Disabilities) will decrease by ____% by (first/second/third/fourth) re-evaluation (6 visits)
3. Patient's ROM of the (cervical/thoracic/lumbar) spine will be increased by _____% by (first/second/third/fourth) re-evaluation. (6 visits)
4. Patient will be able to sleep (without interruptions/with only ⅓ loss of sleep/with only ¼ loss of sleep/with only ½ loss of sleep) at night by the (first/second/third/fourth) re-evaluation
5. Patient will be able to (stand/walk/sit) for _____(minutes/hours) by the (first/second/third/fourth) re-evaluation
6. The patient's headaches (frequency/duration/intensity) will decrease by _____% by the (first/second/third/fourth) re-evaluation

Additional Comments:

E/M

A. Chart review 3,4,5,6,7,8,9,10, _____mins
B. Medical Records review 3,4,5,6,7,8,9,10, _____mins
C. 1:1 Patient Time 15,16,17,18,19,20,21,22,23,24,25, _____mins
D. Post-Consultation Counseling 3,4,5,6,7,8,9,10, _____mins
E. Paperwork and Charting 5,6,7,8,9,10,11,12,13,14,15, _____mins
F. Consulting with other Providers 3,4,5,6,7,8,9,10, _____mins

G. Total E/M _____minutes

99202 15-29 mins	99212 10-19 mins
99203 30-44 mins	99213 20-29 mins
99204 45-59 mins	99214 30-39 mins