

Report Master 7 Classic – Screen Shots

Basic Patient Information & Injury/Accident/Onset Screen

Basic Patient Info and Injury/Accident/Onset Screen - The Current Chart is Adams, Raymond - Visit # 1 - Exam Date 1/21/2004

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Basic Patient Info & Accident/Injury/Onset Description Screen Patient History & Prior Treatment Section Review of Systems Survey Screen

Click this Button to fill in this screen with the data from the Last Visit. Copy Last Visit's Data Click this Button to the right to Clear This Screen of All Data. Clear All Data from This Screen

Click this Button to Clear out Injury/Accident/Onset Data Only. Clear All Injury/Accident/Onset Data Only

Soc. Sec. No. Visit No. or File No. Dominant Hand

1 234847812 Right Left Ambidextrous

Title (Required) Mr. Mrs. Miss Ms. Dr.(male) Dr.(female)

Patient's Full Name (Required) First Name Raymond Last Name Adams Middle Initial

Dates Format: Date of Birth Date of Injury/Onset Month/Day/Year 9/22/1951 1/21/2004 Current Exam (Required) Date Report Requested Date Report Written 1/21/2004

Case Type M. V. Accident Work Comp Independent Medical Exam Slip & Fall Other

Report Type (Required) Narrative Report SOAP Notes Initial Report Interim Final Report Progress Report Re-Exam/Re-evaluation

Insurance Case Numbers Policy Number Claim Number YYZ234847812 398230823097347 Policy Holder (if different than patient) Raymond Adams

Recipient of Report (Appears at the top of Report) Salutation/Attn. Line Do not include Salutation (e.g. Dear Ms. Jones) Do not include an "Attn." line at top of report Do not include Salutation OR "Attn" line

Below, type the name and address of the final recipient, such as the patient's attorney or insurance company. You can also create automated codes of addressees. When creating Codes, simply enter the Code Name as "Addressee". AutoCodes

Name of Firm or Co. Street Address Suite, Room, etc. City or Town, State, Zip

Note: If you want to include "To whom it may concern" as the Salutation, leave the Attn: options below blank.

Attn: Mr. Mrs. Ms. Dr. Attorney First Name Last Name James Smith

Opening Remarks Section Enter any opening remarks to appear at the beginning of your report, and/or simply enter any "OR Codes" from your Code List. AutoCodes {OR INITIAL01}{OR INITIAL02}

Injury/Accident/Onset Section If this is not a Motor Vehicle Accident, type in a full description of the injury or onset in the space below. In the case of a MVA, simply check off the applicable options below. Also indicate below whether this is an injury, accident or the onset of a physical difficulty. The patient reported..... Injury Accident Onset AutoCodes

Vehicle Info Your Vehicle Type Your Position in Vehicle Car S.U.V. Driver Front Passenger Van Pickup Truck Left Rear Passenger Large Truck Bus Right Rear Passenger Other Other

Time/Speed/Damage Time of Accident 10:20 AM Your Vehicle's Speed 55 mph Their Vehicle's Speed 60 mph Damage to your vehicle Mild Moderate Totaled

What was your vehicle doing at the time of the accident? Stopped at intersection Stopped in traffic Stopped at light Making a right turn Making a left turn Parking Proceeding along Slowing down Accelerating Other

Details of Accident Visibility at the time Good Fair Poor Road Conditions at Time of Accident Icy Wet Sandy Dark Clean and Dry

Point of Impact Head-On Rear-End Left front Right front Left rear Right rear Who hit who/what? You hit other vehicle Other vehicle hit you You hit...(type in object below)

Additional Accident Information In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs. AutoCodes Thej aselfj welk fjwlfj welwje lfsjfls jfslj saljfwlwe fjwek flk

During the Accident: Body Position, etc. Did you see the accident coming? Yes No Were you braced for the impact? Yes No Did you have a seat belt on? Yes No Did you have a shoulder harness on? Yes No Did the driver's forward air bag deploy? Yes No Did passenger's forward bag deploy? Yes No Did the side air bags deploy? Yes No Does your vehicle have headrests? Yes No

If Yes, what was the position of the headrest at the time? Even with top of head Even with bottom of head Even with the Middle of the neck

What was the direction of the head at the time of impact? Facing straight Turned to the right Turned to the left forward

Did your body strike the inside of your vehicle? Yes No If Yes, describe My head and left shoulder struck my side window

Did you lose consciousness during the injury? Yes No If Yes, for how long? about a minute Your vehicle's Damage to their vehicle Estimated \$8,000 Mild Moderate Totaled Damage: Did police show up at the scene? Yes No Was an accident report filled out? Yes No

Emergency Room? Where did you go after the accident? Home Work Hospital ER Private doctor How did you get there? Drove self Somebody else Ambulance Police X-rays done? Yes No Was lab work done? Yes No Body parts X-rayed? lower back What lab work? The x-rays revealed... no sign of fractures Treatments: Cervical Collar Ice Other traction Medications: Advil Follow-up Instructions: alternate ice and heat on his neck and left s

After the Accident: Check off the symptoms right after and a few days following accident. Headache Neck pain Neck stiffness Fainting Ringing in ears Loss of smell Pain behind eyes Dizziness Nausea Confusion Fatigue Tension Irritability Shortness of breath Mid back pain Low back pain Nervousness Loss of taste Toe Numbness Constipation Cold feet Cold feet Diarrhea Depression Anxious Chest pain Sleeping problems Other(s) some numbness in both hands, and in the mid back

Patient History and Prior Treatments Screen

History/Treatment Sections - The Current Chart is Adams, Raymond - Visit # 1 - Exam Date 1/21/2004

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Prior Similar Symptoms

I have NOT had prior symptoms similar to my current complaints.
 My current complaints DID exist before, but had been dormant.
 My current complaints ALREADY existed and were worsened.

Has your History Contributed to your Symptoms?

My history HAS contributed to my current symptoms.
 My history HAS NOT contributed to my current symptoms.
 I'm NOT SURE if my history has contributed to my symptoms.

My Most Recent Prior Similar Symptoms (if applicable)

My most recent prior similar symptoms Months Years ...ago
Or on... Date

Medical History Section
Enter additional Medical Historical data relevant to the patient's condition here. Autocodes

Medicals asldjsl:fj sdlafj sadlfsdls jflsdjf lsafrasjfsdlafasdlfjasdlfjasdl asldkfsjkd.

Surgical Historical Section
Enter any Surgical Historical data here. Autocodes

Surgsj fls jdlstdjflsajfweljlqwe fjsjf ojso jflwfwewojkjs lfsalfljasd flasjdlfjasd.

Medications History Section
Enter any Medications Historical data here, particularly related to the patient's current condition. Autocodes

Medica slasdflsfasdlfj asdlfjasdlfjdsdlfjfasdlfjwel jlwfwomkxzclzxcj jsdaflljasd fljasl fsdl.

Occupational History Section
Enter any relevant Occupational History here, such as time lost from work, etc. Autocodes

Occupat s flasdflsajfweljl eljwl fjwlefweljlflsajflsdlfjaskd[fldho:rghsqk]jhkhawekhwkwl wl jlwfl l jwelfkjsdlk.

Familial History Section
Enter any relevant Familial History here, such as number and ages of any children, similar conditions, etc. Autocodes

Family asdjsdl sfllsdlfjasdlfjfasdlfjasdlfjwelkfweljslflkj asdlfjasdlfj flsajlfdlsj lksj.

Social History Section
Enter any relevant Familial History here, such as number and ages of any children, similar conditions, etc. Autocodes

Patient states his job requires alot of sitting and he feels this has alot to do with his symptoms.

Prior Treatment Section
Summarize past treatments received by the patient, with the purpose and any results of those treatments. Autocodes

Prior treat wel jwelfkwlrljwelfjlqwejl wllwewre jl we rljwewlwerl qwelwrljklw.

Additional Historical Information Section
Summarize other treatments have been received, along with the purpose and any results of those treatments. Autocodes

Additional History stuff slfjasdlfls fjwelfj welj ljljlkasjsoisoujasdlfj ljsljlj .

Treatment History 1:
Fill in any other doctor(s) seen prior to your first visit to this

1. Name First Visit ...
Specialty: X-rays done? Yes No
Types of Treatments
How Many Tx's Rec'd? Currently Treating? Yes No
Did Tx's benefit you? Yes No Last Visit Date ...

Treatment History 2:
Fill in any other doctor(s) seen prior to your first visit to this

2. Name First Visit ...
Specialty: X-rays done? Yes No
Types of Treatments
How Many Tx's Rec'd? Currently Treating? Yes No
Did Tx's benefit you? Yes No Last Visit Date ...

Treatment History 3:
Fill in any other doctor(s) seen prior to your first visit to this

3. Name First Visit ...
Specialty: X-rays done? Yes No
Types of Treatments
How Many Tx's Rec'd? Currently Treating? Yes No
Did Tx's benefit you? Yes No Last Visit Date ...

Treatment History 4:
Fill in any other doctor(s) seen prior to your first visit to this

4. Name First Visit ...
Specialty: X-rays done? Yes No
Types of Treatments
How Many Tx's Rec'd? Currently Treating? Yes No
Did Tx's benefit you? Yes No Last Visit Date ...

Patient Review of Systems Screen

Patient Review of Systems Survey - The Current Chart is Adams, Raymond - Visit # 1 - Exam Date 1/21/2004

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Click this Button to fill in this screen with the data from the Last Visit. Copy Last Visit's Data

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Directions: Click on all the boxes that apply by either verbally surveying the patient or by utilizing the Spreadsheet document that we've provided with the software. Any sections that you don't use or need, you can hide them from the screen by clicking on the "Hide Section Tabs" Button to the right.

Hide Section Tabs

<p>Problems with the Head</p> <p>Black Outs Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Concussion Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Dizziness Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Fainting Current <input type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Head Trauma Current <input type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Headaches Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>All above Head Problems Denied All Current Head Problems Denied <input type="checkbox"/> All Past Head Problems Denied <input type="checkbox"/> All Family Head Problems Denied <input type="checkbox"/></p> <p>Additional Problems with the Head Autocodes Thaelj wel jlj lwejf ljsdljsd lfsjlsdjlfsdjl fasdjl sdlkj</p> <hr/> <p>Endocrine System Problems</p> <p>Urinary Problems</p> <p>Hearing Problems</p> <p>Vision Problems</p> <p>Male Reproductive Problems</p> <hr/> <p>Additional Review of Systems Information - Autocodes Gsfkljassfllwk jfwelwj owjfl lsfjwoujwiojmlkxmkjvjskljasdl jsdlk; ljslk jasdjl; k j askl;</p>	<p>Neurological Conditions</p> <p>Alzheimers Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Concussion Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Epilepsy Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Multiple Sclerosis Current <input type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Numbness Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Parkinsons Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Poor Coordination Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Seizures Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Strokes Current <input type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Tingling Sensation Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Walking Difficulties Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Weakness Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>All above Neurologic Conditions Denied All Current Neuro Problems Denied <input type="checkbox"/> All Past Neuro Problems Denied <input type="checkbox"/> All Family Neuro Problems Denied <input type="checkbox"/></p> <p>Additional Neurological Conditions Autocodes Telkjlwrk jwef jlkswje flwfkjlwjkwljwkwjhwelkjlkljfasdl ljeiwowdo.</p> <hr/> <p>Cardiovascular Difficulties</p> <p>Vascular Problems</p> <p>Digestive Problems</p> <p>Respiratory Problems</p> <p>Skin Problems</p> <p>Female Reproductive Problems</p> <p>Childhood Conditions</p>	<p>Musculoskeletal Difficulties</p> <p>Arthritis Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Chronic Fatigue Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Dislocations Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Disc Problems Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Fibromyalgia Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Fractures Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Joint Pain Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Muscle Ache Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Muscle Cramps Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Neck Pain Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Non-Specific Back Pain Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Osteoarthritis Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Osteoporosis Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Rheumatoid Arthritis Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Scoliosis Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>Stiffness Current <input checked="" type="checkbox"/> Denied <input type="checkbox"/> Past <input type="checkbox"/> Family History <input checked="" type="checkbox"/> Family Denied <input type="checkbox"/></p> <p>All above Musculoskeletal Difficulties Denied All Current Musc Conditions Denied <input type="checkbox"/> All Past Musc Conditions Denied <input type="checkbox"/> All Family Musc Conditions Denied <input type="checkbox"/></p> <p>Additional Musculoskeletal Difficulties Autocodes Thej wel jwfkjwllfw lkwj flwjlw lqwejlkljl lqwejlwjl qw lqwejlkljl</p> <hr/> <p>Other Miscellaneous Conditions</p>
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The First of Three Current Symptom Screens

Current Symptoms (Symptoms 1-3) - The Current Chart is Adams, Raymond - Visit # 1 - Exam Date 1/21/2004

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1. Location of 1st Pain

Headaches L R C B
 Front of Head
 Top and/or Sides
 Back of Head

Jaw L R C B
 Eye L R C B
 Neck L R C B
 Upr. Back L R C B
 Mid Back L R C B
 Low Back L R C B
 Chest L R C B
 Abdomen L R C B
 Ribs L R C B
 Buttocks L R C B
 Shoulder L R C B
 Upper Arm L R C B
 Forearm L R C B
 Hand L R C B
 Hip L R C B
 Leg L R C B
 Foot L R C B
 Other Locations:

2. Types of Pain

Dull Numbing
 Throbbing Shooting
 Spasm Cutting
 Sharp Tingling
 Burning Pounding
 Stinging Cramping
 Aching Constricting
 Other Types of Pain:

3. Pain Frequency

Up to 1/4 of awake time
 1/4 to 1/2 of awake time
 1/2 to 3/4 of awake time
 Most all the time

4. Pain Intensity

Doesn't affect daily activities
 Somewhat affects activities
 Seriously affects activities
 Prevents activities

[View Pain Scales](#)

Additional Data on Symptom One:

AutoCodes:

5. Does this Pain Radiate?

Head L R C B
 Neck L R C B
 Shoulder L R C B
 Arm L R C B
 Hand L R C B
 Hip L R C B
 Leg L R C B
 Foot L R C B
 Other Locations of Radiation:

6. Actions Affecting Pain

B=Brings R=Relieves A=Aggravate

	B	A	R
<input checked="" type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Bending Fwd	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Bending Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Bending Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Bending Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Twisting Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Twisting Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Actions:

1. Location of 2nd Pain

Headaches L R C B
 Front of Head
 Top and/or Sides
 Back of Head

Jaw L R C B
 Eye L R C B
 Neck L R C B
 Upr. Back L R C B
 Mid Back L R C B
 Low Back L R C B
 Chest L R C B
 Abdomen L R C B
 Ribs L R C B
 Buttocks L R C B
 Shoulder L R C B
 Upper Arm L R C B
 Forearm L R C B
 Hand L R C B
 Hip L R C B
 Leg L R C B
 Foot L R C B
 Other Locations:

2. Types of Pain

Dull Numbing
 Throbbing Shooting
 Spasm Cutting
 Sharp Tingling
 Burning Pounding
 Stinging Cramping
 Aching Constricting
 Other Types of Pain:

3. Pain Frequency

Up to 1/4 of awake time
 1/4 to 1/2 of awake time
 1/2 to 3/4 of awake time
 Most all the time

4. Pain Intensity

Doesn't affect daily activities
 Somewhat affects activities
 Seriously affects activities
 Prevents activities

[View Pain Scales](#)

Additional Data on Symptom Two:

AutoCodes:

1. Location of 3rd Pain

Headaches L R C B
 Front of Head
 Top and/or Sides
 Back of Head

Jaw L R C B
 Eye L R C B
 Neck L R C B
 Upr. Back L R C B
 Mid Back L R C B
 Low Back L R C B
 Chest L R C B
 Abdomen L R C B
 Ribs L R C B
 Buttocks L R C B
 Shoulder L R C B
 Upper Arm L R C B
 Forearm L R C B
 Hand L R C B
 Hip L R C B
 Leg L R C B
 Foot L R C B
 Other Locations:

2. Types of Pain

Dull Numbing
 Throbbing Shooting
 Spasm Cutting
 Sharp Tingling
 Burning Pounding
 Stinging Cramping
 Aching Constricting
 Other Types of Pain:

3. Pain Frequency

Up to 1/4 of awake time
 1/4 to 1/2 of awake time
 1/2 to 3/4 of awake time
 Most all the time

4. Pain Intensity

Doesn't affect daily activities
 Somewhat affects activities
 Seriously affects activities
 Prevents activities

[View Pain Scales](#)

Additional Data on Symptom Three:

AutoCodes:

Activities of Daily Living Evaluation Screen

ADL Evaluation - The Current Chart is Adams, Raymond - Visit # 1 - Exam Date 1/21/2004

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Activities of Daily Living Scale #1
 Use the following 1 to 5 Scale to describe the difficulties below. 2 - "I can do it without much difficulty, despite some pain." 4 - "I manage to do it, despite the pain, but only if I have help."
 1 - "I can do it without any difficulty." 3 - "I manage to do it by myself, despite marked pain." 5 - "I cannot do it at all, because of the pain."

Difficulties with Self Care and Personal Hygiene Activities
 Bathing... 1 Drying hair... 1 Brushing teeth... 2 Putting on shoes... 2 Preparing meals... 1 Taking out trash... 2 Showering... 2 Combing hair... 3 Making bed... 3
 Tying shoes... 2 Eating... 1 Doing laundry... 3 Washing hair... 3 Washing face... 2 Putting on shirt... 1 Putting on pants... 3 Cleaning dishes... 3 Going to toilet... 3

Difficulties with Physical Activities
 Standing... 2 Walking... 3 Kneeling... 2 Bending back... 3 Twisting left... 3 Leaning back... 3 Sitting... 2 Stooping... 3 Reaching... 3
 Bending left... 2 Twisting right... 3 Leaning left... 2 Reclining... 2 Squatting... 4 Bending forward... 3 Bending right... 3 Leaning forward... 3 Leaning right... 3
 Standing for long periods... 3 Sitting for long periods... 3 Walking for long periods... 4 Kneeling for long periods... 5

Difficulties with Functional Activities
 Carrying small objects... 1 Lifting weights off floor... 4 Pushing things while seated... 3 Exercising upper body... 4 Carrying large objects... 3 Lifting weights off table... 3
 Pushing things while standing... 3 Exercising lower body... 3 Carrying brief case... 2 Climbing stairs... 3 Pulling things while seated... 4 Exercising arms... 3
 Carrying large purse... 4 Climbing inclines... 3 Pulling things while standing... 3 Exercising legs... 4

Difficulties with Social and Recreational Activities
 Bowling... 2 Jogging... 0 Swimming... 2 Ice skating... 0 Competitive sports... 2 Dating... 0 Golfing... 2 Dancing... 0 Skiing... 2
 Roller skating... 0 Hobbies... 2 Dining out... 0

Difficulties with Travelling
 Driving a motor vehicle... 2 As passenger in a motor vehicle... 0 As passenger on a train... 2 Driving for long periods of time... 0 As airplane passenger... 2 As passenger for long periods... 0

Activities of Daily Living Scale #2
 Use the following 1 to 5 Scale to describe the difficulties below. 2 - "This area is slightly affected by my condition." 4 - "My condition seriously limits my ability in this area."
 1 - "This area is not affected by my condition." 3 - "My condition moderately restricts my ability in this area." 5 - "My condition prevents me from using this ability."

Difficulties with Different Forms of Communication
 Concentrating... 3 Hearing... 1 Listening... 4 Speaking... 2 Reading... 4 Writing... 3 Using a keyboard... 3

Difficulties with the Senses **Difficulties with Hand Functions**
 Seeing... 2 Hearing... 2 Touch... 2 Taste... 2 Sense of Smell... 2 Grasping... 2 Holding... 2 Pinching... 2 Percussive movements... 5 Sensory discrimination... 2

Sleep and Sexual Function
 Being able to have a normal, restful nights sleep... 1
 Being able to participate in desired sexual activity... 2

Additional Activities of Daily Living Information **AutoCodes**
 Theasekj ewel twjef ssoiwekjnf2jksniouvhaskn asdkfjasdfkasdkj.ashd f fffasdljf asdljæsd ljasd lj lj.

General Physical Examination Screen

General Physical Exam Section - The Current Chart is Adams, Raymond - Visit # 1 - Exam Date 1/21/2004

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General Physical Exam Screen Range of Motion Testing Screen Muscle & Neurologic Testing Screen Orthopedic Testing Screen Xrays Screen

Click this Button to fill in this screen with the data from the Last Visit. Click this Button to Clear This Screen of Data.

Alert and Cooperative?
 Check for Yes

Antalgic (gait related) Signs
In Distress?
 Negative Positive

Minor's Sign?
 Negative Positive

Spine Tilt?
 Negative Positive
 Tilt Left Tilt Right

Gait Impairment
 Gait OK, OR
Limp Favors
 Left Side
 Right Side

Gait Scale
Enter your Estimated Impairment Percentage OR

Physique
Weight
180.00 Pounds
Kilograms

Height
5 feet
10 inches
fraction
OR
cm

Temperature
89.0 Degrees

Blood Pressure
Systolic Diastolic
125 / 130 Left
75 / 78 Right

Pulse Rate
110 Beats Per Minutes

Heart and Lungs
 Heart Normal, OR
Arrhythmia
 Neg Pos

Murmurs
Mitral
 Neg Pos
Pulmonary
 Neg Pos
Semilunar
 Neg Pos
Tricuspid
 Neg Pos

Lungs Normal, OR
 L.U. R.U.
 L.L. R.L.
 Rales
 Rhonchus
 Wheezing

Eyes, Ears and Throat
 Eyes Normal Ears Normal Throat Normal

Deep Tendon Reflexes
 Click here if all Reflexes are Within Normal Limits

Biceps
Left 3 4 Right

Triceps
Left 3 4 Right

Patellar
Left 4 4 Right

Brachioradialis
Left 3 3 Right

Achilles
Left 4 3 Right

Cranial Nerve Exam
 All Normal

	Norm	Abnormal
Olfactory.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Optic.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Oculomotor.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Trochlear.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Trigeminal.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Abducens.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Facial.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Acoustic.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Glossopharyngeal.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Vagus.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Spinal Accessory.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Hypoglossal.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Visual Inspection
 All WNL on visual inspection

	L	R
Head tilt.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Neck curvature to the side.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Cervical muscle tension.....	<input type="checkbox"/>	<input type="checkbox"/>
High shoulder.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
High scapula.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Thoracic muscle tension.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Thoracic curvature to the side.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Lumbar muscle tension.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
High ilium.....	<input type="checkbox"/>	<input type="checkbox"/>
Left foot rotated to the side.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Right foot rotated to the side.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Patient limps favoring one side.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Atrophy Evaluation
 No Evidence of Atrophy

Upper Arms L 12.00 11.50 R
Forearms L 9.50 9.50 R

Measured In
 Inches
 Cms.

Thighs L 14.50 14.00 R
Calves L 12.25 12.00 R

Additional Physical Examination Information

Then wel f welfjwelwjefw ekfjwelkfewj f w welwejfw jfwel fw lwelkwe jwewkj fweljf wel,f jawklfj wlk.

Range of Motion Testing Screen

Spinal and Extremities Ranges of Motion - The Current Chart is Adams, Raymond - Visit # 1 - Exam Date 1/21/2004

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Click this Button to fill in this screen with the data from the Last Visit. Copy Last Visit's Data Click this Button to Clear This Screen of Data. Clear All Data from This Screen

Instrument(s) Used: Inclinator Goniometer

Cervical Spine ROM

Flexion	Extension
55 <input type="checkbox"/> P	60 <input type="checkbox"/> P
50 <input type="checkbox"/> S	58 <input type="checkbox"/> S
48 <input type="checkbox"/>	57 <input type="checkbox"/>
Norm = 50	Norm = 60

Check, if above is position of Ankylosis

Lateral Flexion

Left	Right
42 <input type="checkbox"/> P	42 <input type="checkbox"/> P
46 <input type="checkbox"/> S	43 <input type="checkbox"/> S
41 <input type="checkbox"/>	45 <input type="checkbox"/>
Norm = 45	

Check, if above is position of Ankylosis

Cervical Rotation

Left	Right
75 <input type="checkbox"/> P	75 <input type="checkbox"/> P
75 <input type="checkbox"/> S	75 <input type="checkbox"/> S
75 <input type="checkbox"/>	75 <input type="checkbox"/>
Norm = 80	

Check, if above is position of Ankylosis

Additional Cervical ROM Information

Additional cerv ROM Info sdjlk we wfwjwsd fsl sdsjl.

AutoCodes

View R.O.M. Instructions

P = Pain S = Spasm

Was an Inclinator Used?
 Yes No

Thoracic Spine ROM

Extension (Angle of Minimum Kyphosis)	Flexion (From "Military Brace" Position)
55 <input type="checkbox"/> P	45 <input type="checkbox"/> P
55 <input type="checkbox"/> S	45 <input type="checkbox"/> S
55 <input type="checkbox"/>	45 <input type="checkbox"/>
Normal is from 0 to 59	

Check, if above is position of Ankylosis

Thoracic Rotation

Left	Right
25 <input type="checkbox"/> P	25 <input type="checkbox"/> P
25 <input type="checkbox"/> S	25 <input type="checkbox"/> S
25 <input type="checkbox"/>	25 <input type="checkbox"/>
Norm = 30	

Check, if above is position of Ankylosis

Additional Thoracic ROM Information

Additional Thoracic ROM Info. lfjds lsdjfd asjdfasj fls.

AutoCodes

Lumbosacral Spine ROM

T12 Flexion	S1 (Hip) Flexion
100 <input type="checkbox"/> P	45 <input type="checkbox"/> P
98 <input type="checkbox"/> S	46 <input type="checkbox"/> S
105 <input type="checkbox"/>	48 <input type="checkbox"/>
T12 minus S1 = True Flexion, normal being greater than 60, if S1 is greater than 45	

T12 Extension - S1 Extension

T12 Extension	S1 Extension
50 <input type="checkbox"/> P	25 <input type="checkbox"/> P
45 <input type="checkbox"/> S	24 <input type="checkbox"/> S
48 <input type="checkbox"/>	28 <input type="checkbox"/>
Normal T12 - S1 (True Extension) = 25	

Lumbosacral Lateral Flexion

Left	Right
22 <input type="checkbox"/> P	22 <input type="checkbox"/> P
22 <input type="checkbox"/> S	22 <input type="checkbox"/> S
22 <input type="checkbox"/>	22 <input type="checkbox"/>
Norm = 25	

Check, if above is position of Ankylosis

Straight Leg Raise

84 Left 90 Right 89

Additional Lumbar ROM Information

Additional Lumbar ROM info aslfj ass aks fsf slsajsf slsij aslaj.

AutoCodes

Range of Motion Evaluation - Short Form

Entire Spine Within Normal Limits
 All Upper Extremis WNL
 All Lower Extremis WNL

Cervical	Thoracic	Lumbar
Cervical Flexion/50: 55 <input type="checkbox"/> P S	Thoracic Extension/0-59: 55 <input type="checkbox"/> P S	Lumbar Flexion/61: <input type="checkbox"/> P S
Cervical Extension/60: 60 <input type="checkbox"/> P S	Thoracic Flexion/50: 45 <input type="checkbox"/> P S	Lumbar Extension/25: <input type="checkbox"/> P S
Left Lateral Flexion/45: 42 <input type="checkbox"/> P S	Left Rotation/30: 25 <input type="checkbox"/> P S	Left Lateral Flexion/25: 22 <input type="checkbox"/> P S
Right Lateral Flexion/45: 42 <input type="checkbox"/> P S	Right Rotation/30: 25 <input type="checkbox"/> P S	Right Lateral Flexion/25: 22 <input type="checkbox"/> P S
Left Rotation/80: 75 <input type="checkbox"/> P S		
Right Rotation/80: 75 <input type="checkbox"/> P S		

Additional Range of Motion Information

AutoCodes

Upper Extremities Ranges of Motion

Wrist

Flexion	Extension
45 <input type="checkbox"/> P	45 <input type="checkbox"/> P
45 <input type="checkbox"/> S	45 <input type="checkbox"/> S
45 <input type="checkbox"/>	45 <input type="checkbox"/>

Check, if above is position of Ankylosis

Radial Deviation - Ulnar Deviation

Left	Right	Left	Right
12 <input type="checkbox"/> P	12 <input type="checkbox"/> P	20 <input type="checkbox"/> P	20 <input type="checkbox"/> P
12 <input type="checkbox"/> S	12 <input type="checkbox"/> S	20 <input type="checkbox"/> S	20 <input type="checkbox"/> S
12 <input type="checkbox"/>	12 <input type="checkbox"/>	20 <input type="checkbox"/>	20 <input type="checkbox"/>

Check, if above is position of Ankylosis

Elbow

Flexion	Extension
135 <input type="checkbox"/> P	0 <input type="checkbox"/> P
135 <input type="checkbox"/> S	0 <input type="checkbox"/> S
135 <input type="checkbox"/>	0 <input type="checkbox"/>

Check, if above is position of Ankylosis

Pronation - Supination

Left	Right	Left	Right
75 <input type="checkbox"/> P	75 <input type="checkbox"/> P	75 <input type="checkbox"/> P	75 <input type="checkbox"/> P
75 <input type="checkbox"/> S	75 <input type="checkbox"/> S	75 <input type="checkbox"/> S	75 <input type="checkbox"/> S
75 <input type="checkbox"/>	75 <input type="checkbox"/>	75 <input type="checkbox"/>	75 <input type="checkbox"/>

Check, if above is position of Ankylosis

Additional Upper Extremity ROM Data

Thelkjs sdsjlsdfsdjfd asfjslksjds sfsdlk sfl jlj j safdsf slkjasdkj.

AutoCodes

Shoulder

Flexion	Extension
175 <input type="checkbox"/> P	45 <input type="checkbox"/> P
175 <input type="checkbox"/> S	50 <input type="checkbox"/> S
175 <input type="checkbox"/>	45 <input type="checkbox"/>

Check, if above is position of Ankylosis

Abduction - Adduction

Left	Right	Left	Right
175 <input type="checkbox"/> P	175 <input type="checkbox"/> P	45 <input type="checkbox"/> P	45 <input type="checkbox"/> P
175 <input type="checkbox"/> S	175 <input type="checkbox"/> S	45 <input type="checkbox"/> S	45 <input type="checkbox"/> S
175 <input type="checkbox"/>	175 <input type="checkbox"/>	45 <input type="checkbox"/>	45 <input type="checkbox"/>

Check, if above is position of Ankylosis

External Rotation - Internal Rotation

Left	Right	Left	Right
85 <input type="checkbox"/> P	85 <input type="checkbox"/> P	85 <input type="checkbox"/> P	85 <input type="checkbox"/> P
85 <input type="checkbox"/> S	85 <input type="checkbox"/> S	85 <input type="checkbox"/> S	85 <input type="checkbox"/> S
85 <input type="checkbox"/>	85 <input type="checkbox"/>	85 <input type="checkbox"/>	85 <input type="checkbox"/>

Check, if above is position of Ankylosis

Lower Extremities Ranges of Motion Measurements

Hip

Flexion	Extension
95 <input type="checkbox"/> P	5 <input type="checkbox"/> P
95 <input type="checkbox"/> S	0-9 <input type="checkbox"/> S
95 <input type="checkbox"/>	5 <input type="checkbox"/>

Check, if above is position of Ankylosis

Internal Rotation - External Rotation

Left	Right	Left	Right
15 <input type="checkbox"/> P	15 <input type="checkbox"/> P	25 <input type="checkbox"/> P	25 <input type="checkbox"/> P
15 <input type="checkbox"/> S	15 <input type="checkbox"/> S	25 <input type="checkbox"/> S	25 <input type="checkbox"/> S
15 <input type="checkbox"/>	15 <input type="checkbox"/>	25 <input type="checkbox"/>	25 <input type="checkbox"/>

Check, if above is position of Ankylosis

Abduction - Adduction

Left	Right	Left	Right
20 <input type="checkbox"/> P	20 <input type="checkbox"/> P	10 <input type="checkbox"/> P	10 <input type="checkbox"/> P
20 <input type="checkbox"/> S	20 <input type="checkbox"/> S	10 <input type="checkbox"/> S	10 <input type="checkbox"/> S
20 <input type="checkbox"/>	20 <input type="checkbox"/>	10 <input type="checkbox"/>	10 <input type="checkbox"/>

Check, if above is position of Ankylosis

More Lower Extremity ROM Data

More Lower extrem ROM data asdlkwe welj wejksadlksda lsjljasdj asrklksai

AutoCodes

Knee

Flexion	Flexion Contracture
105 <input type="checkbox"/> P	3 <input type="checkbox"/> P
105 <input type="checkbox"/> S	0-4 <input type="checkbox"/> S
105 <input type="checkbox"/>	2 <input type="checkbox"/>

Check, if above is position of Ankylosis

Varus - Valgus

Left	Right	Left	Right
25 <input type="checkbox"/> P	25 <input type="checkbox"/> P	5 <input type="checkbox"/> P	5 <input type="checkbox"/> P
25 <input type="checkbox"/> S	25 <input type="checkbox"/> S	5 <input type="checkbox"/> S	5 <input type="checkbox"/> S
25 <input type="checkbox"/>	25 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>

Check, if above is position of Ankylosis

Ankle

Plantar Flexion	Dorsiflexion
15 <input type="checkbox"/> P	8 <input type="checkbox"/> P
15 <input type="checkbox"/> S	10+ <input type="checkbox"/> S
15 <input type="checkbox"/>	8 <input type="checkbox"/>

Check, if above is position of Ankylosis

Toe

Great Toe Flexion	Great Toe Extension
15 <input type="checkbox"/> P	25 <input type="checkbox"/> P
15 <input type="checkbox"/> S	30+ <input type="checkbox"/> S
15 <input type="checkbox"/>	25 <input type="checkbox"/>

Check, if above is position of Ankylosis

Muscle and Neurologic Testing Screen

Muscle and Neurologic Testion Section - The Current Chart is Adams, Raymond - Visit # 1 - Exam Date 1/21/2004

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Enter other upper extrem or neck muscles info below that you want to appear at the top of the Muscle Testing Section of the Report Double Click on any of the text boxes on this page to bring up an easy click version of the Muscle Testing Scales. Click to View Muscle Rating Scales

Positive/Present = P Negative/Absent = N Description = D Diagnosis = Dx

Neck and Upper Extremities Testing

Neck Flexors & Extensors
(Ventral & Dorsal Rami, C3-C8)
Flexion Extension
4 5
Flexes and Extends the Neck and Head Forward and Back

Scalene Muscle Group
Left Right
3 3
Laterally Flexes & Rotates Cervical Spine to the Opposite Side

Dorsal Scapular (C5)
Long Thoracic (C5,6,7)
Thoracodorsal (C6,7,8)
Suprascapular(C5,C6)
Axillary(Post.Branch)(C5,6)
Pectorals (C5,6,7,8,T1)
Axillary (C5,C6)
Subscapularis(C5,6,7)
Musculocutaneous (C5,6,7)
Radial(Upper Arm)(C6,7,8)

Forearm (C5-T1)
Radial (Elbow with sparing of Triceps) (C5,6,7,8,T1)
Anconeus(C7,8,T1)
Left Right
4 3
Extension and Pronation of Forearm at the Elbow

Brachioradialis(C5,6,7)
Left Right
3 3
Flexion of the Forearm at the Elbow

Supinator(C5,6)
Left Right
5 2
Supinates the Forearm

Extensor Carpi (C6,7,8)
Median (C6,7,8)
Median & Ulnar (C7,8,T1)
More Upper Extrem Info

Lower Extremities Muscle Testing

Femoral (L2,3,4)
Psoas Major (L1,2,3) and Iliacus (L2,3)
Left Right
3 4
Flexes Thigh at the Hip

Sartorius (L2,3)
Left Right
4 5
Flexes, Laterally Rotates and Abducts the Thigh

Quadriceps (L2,3,4)
Left Right
3 2
Extends the Leg at Knee

Superior Gluteal (L4,5,S1)
Obturator (L2,3,4)
Sciatic (L5,S1,2)
Inferior Gluteal (L5,S1,2)
Common Peroneal (L1-5)
Common Peroneal (L5-S2)
Lateral Plantar (S2,3)
Medial Plantar (S2,3)
More Lower Extrem Info

Grip Strength and Girth Testing

Grip Strength is Within Normal Limits

Dynamometer Used
Jamar Collins
Other

Grip Measurements Used
Pounds Kilograms

Hand Grip Figures

L	33.00	32.00	R
L	30.00	29.00	R
L	34.00	31.00	R

Repeat Grip test 3 times at different times during the examination. Grip Tests are considered reliable if there is LESS than 20% variation between the three sets of tests. If there is more than 20% variation, repeat the test.

Girth Evaluation

Short Form Dermatomome Evaluation

Dermatome Evaluation
Upper Extrem WNL Lower Extrem WNL

Nerve	Root	Location	Pain	Hypo-esthesia	Hyper-esthesia	(Double Click) Rate	WNL
C5	L	R	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2	<input type="checkbox"/>
C6	L	R	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2	<input type="checkbox"/>
C7	L	R	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3	<input type="checkbox"/>
C8	L	R	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2	<input type="checkbox"/>
T1	L	R	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2	<input type="checkbox"/>
L3	L	R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>
L4	L	R	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2	<input type="checkbox"/>
L5	L	R	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3	<input type="checkbox"/>
S1	L	R	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2	<input type="checkbox"/>

Additional Dermatomome Information AutoCodes

Sensory Rating Full Sensory Impairment Testing

Sensory Testing Method & Dermatomes Normal

Sensory Testing Method Used
 Pinwheel Hot/Cold
 Aesthesiometer Pressure
Other

Dermatomes Normal
 All Upper Extremity Dermatomes Normal
 All Lower Extremity Dermatomes Normal

Dermatome Area 1
Dermatome Area 2
Dermatome Area 3
Dermatome Area 4
Dermatome Area 5
Dermatome Area 6
Dermatome Area 7
Dermatome Area 8

Pathologic Reflexes

Platysma Sign
P N Left Right D Dx

Snout Reflex
Zygomatic Reflex
Finger Thumb Reflex
Kleist's Hooking Sign
Klippel-Weil Sign
Babinski Reflex
Gordon's Reflex
Oppenheim Sign
Strumpell's Tibialis Anterior Sign

Auditory Nerve Disorders

Bing's Test
P N Left Right D Dx

Gruber Test
Rinne Test
Weber (Lateralization) Test

Clonus Tests

Wrist Clonus
P N Left Right D Dx

Ankle Clonus
Suprapatellar Reflex
Trepidation Sign

Posterior Column Disorders

Finger to Finger Test
P N D Dx
 Can only hit mark w/eyes open
 Can't hit w/eyes open or closed

Finger to Nose Test
Heel-Knee Test
Heel-Toe, Lhermitte's, Romberg

Brachial Plexus Disorders

Bikele's Sign
P N Left Right D Dx

Peripheral Nerve Tests

Biceps Reflex
Biceps Reflex
P N Left Right D Dx

Brachioradialis Reflex
Infraspinatus Reflex
Pectoral Reflex
Radial Reflex
Inverted Radial Reflex
Ulnar Reflex
Tinell Sign
Phalen Sign
Wartenberg's (Prayer) Sign

Lumbosacral Nerve Tests

Heel-Walk Test
P N D Dx

O'Connell's Test
Quadriceps Reflex
Toe Walk Test

Additional Neurological

Additional Neurological Data
Enter any additional Neurological Data here. AutoCodes

Electrodiagnostic Findings

Orthopedic Testing Screen

Orthopedic Testing - The Current Chart is Adams, Raymond - Visit # 1 - Exam Date 1/21/2004

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Spinal Lesion Tests

Positive/Present = P Description = D
Negative/Absent = N Diagnosis = Dx

Bakody Sign

Bakody Sign
P N Left Right Dx

Cervical Distraction Test

Jackson Compression

Maximum Cervical Compression

Shoulder Depression

Soto-Hall Test

Spurling's Test

Valsalva Maneuver

Additional Cervical Lesion Data

Chest Expansion Test

Forestier's Bowstring Sign

Lewin Supine Test

Additional Thoracic Lesion Tests

Adam's Sign

Demianoff's Sign

Double Leg Raise Test

Duchenne's Sign

Goldthwait's Sign

Hyperextension Tests

Lasegue Differential Sign

Lewin Punch Test

Lindner's Sign

Nachlas' Test

Smith-Peterson Test

Additional Lumbar Lesion Tests

Sacroiliac/Sciatic Lesion Tests

Positive/Present = P Description = D
Negative/Absent = N Diagnosis = Dx

Anterior Innominate Test

Anterior Innominate Test
P N Left Right Dx

Erichsen's Sign

Gaenslen's Test

Lewin-Gaenslen's Test

Gillis' Test

Hibb's Test

Iliac Compression Test

Laguerre's Sign

Sacroiliac Resisted Abduction

Sacroiliac Stretch Test

Yeoman's Test

Additional Sacroiliac Lesion Data

Bonnet's Sign

Bragard Sign

Deyerle's Sciatic Tension Test

Sicard's Sign

Turyrn's Sign

Additional Sciatic Lesion Data

Lasegue Straight Leg Raise Tests

Lasegue Straight Leg Raise #1

Lasegue Test #1
P N Left Right D

Angle of Flexion at which pain occurs... 45

Location of Pain... L4 to S1

Pain Intensity
 Mild Moderate Extreme Audibilized

Lasegue Straight Leg Raise #2

Disk & Soft Tissue Lesions

Positive/Present = P Description = D
Negative/Absent = N Diagnosis = Dx

Amoss' Sign

Amoss' Sign
P N D Dx

Astrom Suspension Test

Bechterew's Sitting Test

Bowstring Sign

Cox Sign

Dejerine's Sign

Fajersztajn's Test

Kemp's Test

Lasegue Rebound Test

Lewin Snuff Test

Milgrams's Test

Naffziger's Test

Sitting Root Test

Additional Disk Lesion Tests

Ciliopupillary Reflex

Huntington's Sign

Morquio's Sign

O'Connell's Test

Thomas' Sign

Additional Nervous System Tests

Sign of the Buttock

Hueter's Fracture Sign

Manual Percussion Test

Mennell's Test

Murphy's Punch Test

Percussion Test

Thompson's Test

Additional Misc. Lesion Tests

Upper & Lower Extrem Tests

Positive/Present = P Description = D
Negative/Absent = N Diagnosis = Dx

Codman's Sign

Codman's Sign
P N Left Right Dx

Cozen's Test

Dawbarn's Sign

Dugas' Test

Hamilton's Ruler Test

Maisonneuve's Sign

Mil's Maneuver

Shoulder Compression Test

Supraspinatus Press Test

Yergason's Test

Additional Upr. Extrem Tests

Ely Heel to Buttock Test

Hip Abduction Stress Test

Laguerre's Sign

Patrick's Test (FABERE Sign)

Thomas' Test

Trendelenburg Test

Additional Hip Lesion Tests

Lewin Standing Test

Nerl's Bowing Sign

Tripod Sign

Additional Hamstring Tests

Abduction Stress Test

Adduction Stress Test

Apley Test

Childress Duck Waddle Test

Dreyer's Sign

Ely's Sign

Hennequin's Sign

Anterior Foot Draw Sign

Hoffa's Sign

Metatarsal Test

Strunsky's Sign

Additional Lowr. Extrem. Tests

Circulatory & AP Curves Tests

Positive/Present = P Description = D
Negative/Absent = N Diagnosis = Dx

Adson's Test

Adson's Test
P N Left Right Dx

Allen's Test

Buerger's Test

George's Test

Homan's Sign

Moskowitz Test

Wright's Test

Additional Circulatory Tests

Burn's Bench Test

Lasegue Sitting Test

Magnuson's Test

Additional Malingering Tests

Anterior Gravitation of the Head

Head Tilt

High Shoulder

High Ilium

Scoliosis

Cervical Curve

Upper Thoracic Kyphosis

Mid Thoracic Kyphosis

Lumbar Lordosis

Additional Orthopedic Test Data

X-ray Evaluation Screen

X-Ray Evaluation Screen - The Current Chart is Adams, Raymond - Visit # 1 - Exam Date 1/21/2004

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X-Ray Study Date
1/7/2013

Cervical Views

Anterior/Posterior

Lateral

Oblique

Left Right

Atlas-Axis

Mentio-Vertex

APOM

Flexion Study

Extension Study

Stress Views

Davis Series

Thoracic Views

Anterior/Posterior

Upright

Recumbent

Posterior Adjacent

Lateral

Upright

Recumbent

Anterior Oblique

Left Right

Posterior Oblique

Left Right

Swimmer's Projection

Lumbar Views

Anterior/Posterior

Upright

Recumbent

Lateral

Upright

Recumbent

Oblique

Left Right

Spot Lateral

Additional Views

Cervical Autocodes

The lej lwek-fj welaifalkf wjelwewkj
fweljfiasdlfkjsdlsd jfk.siflasd ifsdifsk.dljfiasd
fskjsdflk

Thoracic Autocodes

Ther hseif jsekf jeal.fiwel.j wjelwewkj
iflasdifsak.jasdlfj asdlkfj asdlkf.sifl
kasidflasdlfk.asid sdik.

Lumbar Autocodes

Fierek.lj sdfsasj flwiefowewifosdlf asd ifsdiklj
sdofjsdolfaweioifj weoj sdofjsdlk. ifsdif.asdl.

Other Autocodes

Faseflwjea flawije flajj lasdlf slfjsdalljassd
lfjfk.jsdallj jslfwje welj wli lj lasdlf fassdlfjassdlf
asdl jl.

Suspected by viewing X-Rays

No Fractures Suspected

No Gross Osseous Pathology

No Anomalies Suspected

No Distortions Suspected

Facets Appear Normal

Luschka Joints Appear Intact

No Pathological Calcinosis

None of the above suspected

Pathology Revealed by X-Rays

1 = Slight 2 = Moderate
3 = Marked 4 = Extreme

Calcinosis of Ab. Aorta

1 2 3 4

Spondylosis

1 2 3 4

or Negative

Osteoporosis

1 2 3 4

or Negative

Degenerative Arthritis

1 2 3 4

or Negative

Spina Bifida

Negative Positive

Level(s) Affected

Disc Narrowing

1=Slight 2=Moderate Neg = Negative
3=Marked 4=Extreme or Not Present

1 2 Neg Level(s)

3 4 C4/5

1 2 Neg Level(s)

3 4 T3-5

1 2 Neg Level(s)

3 4 L5/S1

1 2 Neg Level(s)

3 4 T5-12

Osteophytosis

Biomechanics Alterations

Foraminal Encroachment

View Spondy Scale

Retrospondyololsthesis

1 = 1% to 25% Slippage
2 = 26% to 50%
3 = 51% to 75%
4 = 76% to 100%
Neg = Negative or Not Present

1 2 Neg Level(s)

3 4 L5/S1

1 2 Neg Level(s)

3 4 T12/L1

1 2 Neg Level(s)

3 4 T12/L1

1 2 Neg Level(s)

3 4 C7/T1

1 2 Neg Level(s)

3 4 L3/4

Spondyololsthesis

Motion Studies (Extension)

Hypermobility & Hypomobility

1=Slight 2=Moderate Neg = Negative
3=Marked 4=Extreme or Not Present

Hypermobility

1 2 Neg Level(s)

3 4 L3-S1

1 2 Neg Level(s)

3 4 T5-10

Hypomobility

1 2 Neg Level(s)

3 4 T12-S1

1 2 Neg Level(s)

3 4 C3-7

Aberrant Movement (Extension)

Motion Study (Flexion)

Hypermobility & Hypomobility

1=Slight 2=Moderate Neg = Negative
3=Marked 4=Extreme or Not Present

Hypermobility

1 2 Neg Level(s)

3 4 C3-6

1 2 Neg Level(s)

3 4 L5/S1

Hypomobility

1 2 Neg Level(s)

3 4 T2-8

1 2 Neg Level(s)

3 4 T11-L2

Aberrant Movement (Flexion)

Translation & Angular Motion

(abnormal back-and-forth motion)

Reference: A.M.A. Guides, pages 98 and 99. (4th Edition)

Spine Segment C4/5

Millimeters of Translation 3.0

Spine Segment L4/5

Millimeters of Translation 3.0

Spine Segment T11/12

Millimeters of Translation 3.0

Abnormal Angular Motion

Additional X-Ray Information

Enter any additional X-Ray findings here, and/or simply enter any applicable "XR Codes" from your AutoCodes List.

{XR02}{XR03}{XR05}{XR01}

Autocodes

Palpation, Today's Treatment & Assessment Screen

Palpation, Today's Treatment & Assessment Screen - The Current Chart is Adams, Raymond - Visit # 1 - Exam Date 1/21/2004

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Palpation, Today's Treatment & Assessment Future Care Plan and Diagnosis, Prognosis, Treatment & Closing Comments

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Click this Button to Clear This Screen. Clear All Data from This Screen

View Palpation Scale

Paraspinal Studies

WNL = Within Normal Limits

Suboccipital

WNL Left Right

Inion Left Right

Paracervical

Upper Thoracic Spine

Mid Thoracic Spine

Thoracolumbar

Lumbar

Coccyx

Lymphatics

Cervical

WNL Left Right

Axial

Inguinal

Abdominal Regions Upper & Lower Quadrants

Upper

WNL Left Right

Lower

Trigger Point Studies

Trapezius

WNL Left Right

Rhomboids

Mid Scapular

Gluteal

Abdominal Regions

Epigastrium

WNL

Umbilical

Hypogastrium

McBurney's Point

Visceral Studies

WNL = Within Normal Limits

Salivary

WNL Left Right

Thyroid

Breast

Ileocecal Valve

Liver

Spleen

Solar Plexus

Rib Evaluation

For Analysis, enter appropriate letter(s) and/or numbers from Palpation Scale

Rib Area 1

WNL Rib Level(s) T- []

Left Anterior

Right Posterior

Analysis

Rib Area 2

Rib Area 3

Rib Area 4

More Palpation Info

More palpation asdfjsdl
kfsdlkf jsdfljdsd lfkjsdlksj asdlj
fij sfdkl jsdflkj sdik fljsjd lkjd
lsdjflskj sdl.

AutoCodes

Today's Modalities Done

Check off and/or fill in below all that apply to the patient today

Use your Modalities List here to include your own modalities. Modality List

GP60, IFL, MS30, MW

- 1. Ultrasound
- 2. Home exercises
- 3. Moist heat
- 4. Cervical collar
- 5. Cervical traction
- 6. Hydro-therapy
- 7. Physio-therapy
- 8. Spinal traction
- 9. General articularatory treatment
- 10. Cryotherapy
- 11. EMS
- 12. Massage
- 13. Diathermy
- 14. Whirlpool
- 15. Lumbar traction
- 16. Long axis traction
- 17. Intersegmental mobilization
- 18. Physical therapy exercises
- 19. Spinal manipulation
- 20. Intersegmental traction
- 21. Interferential current
- 22. Trigger point therapy
- 23. Chiropractic adjustments
- 24. Corrective spinal exercises
- 25. Resistive exercises

Enter any additional Treatment data here and/or use Autocode(s)

Treatment sdijsd lfasd lf asjdflsdajfasdljfasdljfasdlj sdijsdflksajd flsajdl asjdklfasdlj asdljdsik.

AutoCodes

Today's Treatment Goals

Check off and/or fill in below all that apply to the patient today.

- 1. Decrease pain
- 2. Decrease muscle spasm
- 3. Increase ability to perform ADLs
- 4. Return to pre-clinical status
- 5. Increase function
- 6. Stabilize unstable segments
- 7. Achieve maximum medical improvement
- 8. Achieve maximum chiropractic improvement
- 9. Reduce frequency & severity of probable exacerbations.
- 10. Relieve symptom of exacerbation
- 11. Minimize recurrence of clinical status
- 12. Decrease swelling & inflammation
- 13. Increase range of motion
- 14. Increase strength
- 15. Return to pre-injury status
- 16. Retard further degeneration
- 17. Correct muscle imbalance
- 18. Increase flexibility
- 19. Improve alignment

Enter any additional Treatment Goals and/or use Autocode(s)

Treatment Goals sdijsdl fjsklfj slsj lasjsl jsfdljasdljsadl jasfdljasfdl asl lasdlj {%2SP}

AutoCodes

Today's Assessment/Diagnosis

Check off and/or fill in all that apply.

- 1. (First Visit) Favorable results are expected for this patient.
- 2. The patient is progressing as expected.
- 3. The patient is progressing slower than expected.
- 4. Pt. receiving med. necessary therapeutic care; not yet at MMI.
- 5. At [] % of MMI & receiving necessary care.
- 6. **Temporary Total Disability:** Patient will be unable to perform normal work functions through to... []
- 7. **Temporary Partial Disability:** Patient is able to perform home & work functions but is being restricted by...
- 8. **Excellent prognosis:** Uncomplicated case; continuing improvement expected; permanent residuals not expected.
- 9. **Good prognosis:** Complicated case; but continued improvement expected with permanent residuals possible.
- 10. **Fair prognosis:** Complicated case; but continued improvement expected with permanent residuals probable.
- 11. The patient has experienced no improvement since last visit.
- 12. The patient has experienced minor improvement since last visit.
- 13. The patient has experienced moderate improvement since last visit.
- 14. The patient has experienced marked improvement since last visit.

Enter additional Assessment and/or Diagnosis data here.

Diagnosis asdkffwewhjejsd lasfdljasdl fsjl fsl fjkfsfjsjdsiflisd flsdijsdl flsajd.

AutoCodes

Future Care, Diagnosis, Prognosis & Treatment Screen

Patient's Future Care Plan - The Current Chart is Adams, Raymond - Visit # 1 - Exam Date 1/21/2004

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Palpation, Today's Treatment & Assessment **Future Care Plan and Diagnosis, Prognosis, Treatment & Closing Comments**

Click this Button to fill in this screen with the data from the Last Visit. Copy Last Visit's Data

Click this Button to Clear This Screen of Data. Clear All Data from This Screen

Diagnosis Section
Enter your Diagnosis, and/or enter any "E Codes", "ICD-9-CM Codes", or "DX Codes" from your Codes List that apply.

AutoCodes

Diagnosis asdlkfjweflweljsd lasdfjlasdj fsj fsl fjklsfjsjdsjfsjds fjsjdsdkjsd fjlajsd.

{%2SP}

Patient's Current Care Phase
Check off one or more of the following care phases the patient is currently in.

1. Relief Care Phase (Acute)

2. Therapeutic Care Phase (Subacute)

3. Rehabilitative Care Phase

4. Supportive Care Phase (Chronic)

5. Palliative Care Phase

6. Maintenance/Preventive Phase

Enter any additional Care Phase information here and/or use Autocode(s) AutoCodes

Additional care phase askjdsd fslfj sdjlsjdsdkfj sdk jsjlsj lksj lksjfdj kj. {%2SP}

Future Treatment Plan
Check off and/or fill in below all that apply to the patient today

Use your Modalities List here to include your own modalities.

Modality List

CB,EMS,I,MEMS,W,H,W,C

1. Ultrasound

2. Home exercises

3. Moist heat

4. Cervical collar

5. Cervical traction

6. Hydro-therapy

7. Physio-therapy

8. Spinal traction

9. General articularatory treatment

10. Cryotherapy

11. EMS

12. Massage

13. Diathermy

14. Whirlpool

15. Lumbar traction

16. Long axis traction

17. Intersegmental mobilization

18. Physical therapy exercises

19. Spinal manipulation

20. Intersegmental traction

21. Interferential current

22. Trigger point therapy

23. Chiropractic adjustments

24. Corrective spinal exercises

25. Resistive exercises

Enter any additional Modalities data here and/or use Autocode(s)

Additional modalities data lsdj fslajsl fjslasjsajslfjs lfsjls alfsjdkjasj lasjfl k. {%2SP}

AutoCodes

Future Treatment Plan Goals
Check off and/or fill in below all that apply to the patient today.

1. Decrease pain

2. Decrease muscle spasm

3. Increase ability to perform ADLs

4. Return to pre-clinical status

5. Increase function

6. Stabilize unstable segments

7. Achieve maximum medical improvement

8. Achieve maximum chiropractic improvement

9. Reduce frequency & severity of probable exacerbations.

10. Relieve symptom of exacerbation

11. Minimize recurrence of clinical status

12. Decrease swelling & inflammation

13. Increase range of motion

14. Increase strength

15. Return to pre-injury status

16. Retard further degeneration

17. Correct muscle imbalance

18. Increase flexibility

19. Improve alignment

Enter any additional Treatment Goals and/or use Autocode(s)

Additional Treatments goals aslfs ljslfaslsj lsjsjdsdl lasj fjsdflsdl lasdfjsdlsj fl. {%2SP}

AutoCodes

Prognosis Section
Enter your Prognosis for the patient, and/or simply enter any "PRG Codes" from your Codes List that apply.

AutoCodes

Prognosis sldj fl wjefl wjelsjksajlasdj lasdfj sladjasdlj fasdl sdj fjaslkj sdjl flasfjd lasfd j.

Treatment Frequency & Duration
Check off the Frequency & Duration of your proposed care plan.

Treatment Frequency

0. Once every other week

1. Once a week

2. Twice a week

3. Three times a week

4. Four times a week

5. Daily

Treatment Duration

1 wk. 2 wks. 3 wks.

4 wks. 5 wks. 6 wks.

7 wks. 8 wks.

3 mos. 6 mos. 1 year

Enter any additional Frequency and/or Duration information here and/or use Autocode(s) AutoCodes

Additional frequency and duration aslfs lfsfjasd lfsdflsdlj slsjsdlfj lajasd l. {%2SP}

Current Treatment Section
Enter current treatments, along with purpose & expected results, and/or enter any "TRT Codes" that apply.

AutoCodes

Treatment sdlkjsd lfasd lf asdfdsdajfasdlfjasdlj sdlfasdfikasjd flajsd lasdkjasdlf asdljsdlk.

{%2SP}

Closing Comments Section
Enter your Closing Comments, and/or simply enter any "C Codes" from your Codes List that apply.

AutoCodes

Closing Comments sdjfsdlfj welfjwelf lkwej flwej wlfj welkjdl lkjsdlkj asdfjsd fljwekljwelkj welf lsdjfl sldjflsdjfasdl.

Subjective Complaints Screen for SOAP Notes

Subjective Complaints - The Current Chart is Adams, Raymond - Visit # 1 - Exam Date 1/21/2004

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SOAP - Subjective Complaints SOAP - Objective Testing SOAP - Old Objective Short Form SOAP - Assessment, Current Treatment & Future Care Plan

Click this Button to fill in this screen with the data from the Last Visit. Copy All Last Visit's Data Click this Button to Clear This Screen of Data. Clear All Data from This Screen

<p>1st Symptom - low back pain</p> <p>1. Has complaint <input type="radio"/> ...improved a bit? <input type="radio"/> ...improved a lot? <input checked="" type="radio"/> ...gotten a bit worse? <input type="radio"/> ...gotten a lot worse?</p> <p>2. Pain Scale Enter the 0 to 10 figure from the patient here. 4</p> <p>3. Frequency <input type="radio"/> Under 25% of awake time. <input type="radio"/> 25% to 50% of awake time. <input checked="" type="radio"/> 51% to 75% of awake time. <input type="radio"/> 76% to all of awake time.</p> <p>4. Intensity <input type="radio"/> Not affecting activities. <input type="radio"/> Some affect on activities. <input checked="" type="radio"/> Seriously affects activities. <input type="radio"/> Prevents certain activities.</p> <p>5. When worse? <input type="radio"/> In the morning hours. <input type="radio"/> In the afternoon hours. <input type="radio"/> In the evening hours. <input checked="" type="radio"/> At bedtime.</p>	<p>Use this space to type in any NEW symptoms, or additional information, as described by the patient. You can also use the space below to add any additional information (not covered elsewhere), that the patient would like to include. AutoCodes</p> <p>Ther el lkj fwl fjkj sdfj asdfkjsjdfldf jasdflj asdlsd fsdlk fjsdal;kfj asdfi jasd;l:sjd lsdflsd fjsdl; fslfj sd sd asdl fjsdl;j sdlfj sdjl sdlfjsd fklasd.{%2SP}</p>
<p>2nd Symptom - hip pain</p> <p>1. Has complaint <input type="radio"/> ...improved a bit? <input type="radio"/> ...improved a lot? <input checked="" type="radio"/> ...gotten a bit worse? <input type="radio"/> ...gotten a lot worse?</p> <p>2. Pain Scale Enter the 0 to 10 figure from the patient here. 3</p> <p>3. Frequency <input type="radio"/> Under 25% of awake time. <input checked="" type="radio"/> 25% to 50% of awake time. <input type="radio"/> 51% to 75% of awake time. <input type="radio"/> 76% to all of awake time.</p> <p>4. Intensity <input type="radio"/> Not affecting activities. <input type="radio"/> Some affect on activities. <input checked="" type="radio"/> Seriously affects activities. <input type="radio"/> Prevents certain activities.</p> <p>5. When worse? <input type="radio"/> In the morning hours. <input type="radio"/> In the afternoon hours. <input checked="" type="radio"/> In the evening hours. <input type="radio"/> At bedtime.</p>	
<p>3rd Symptom - abdominal pain</p> <p>1. Has complaint <input type="radio"/> ...improved a bit? <input type="radio"/> ...improved a lot? <input checked="" type="radio"/> ...gotten a bit worse? <input type="radio"/> ...gotten a lot worse?</p> <p>2. Pain Scale Enter the 0 to 10 figure from the patient here. 3</p> <p>3. Frequency <input type="radio"/> Under 25% of awake time. <input checked="" type="radio"/> 25% to 50% of awake time. <input type="radio"/> 51% to 75% of awake time. <input type="radio"/> 76% to all of awake time.</p> <p>4. Intensity <input type="radio"/> Not affecting activities. <input checked="" type="radio"/> Some affect on activities. <input type="radio"/> Seriously affects activities. <input type="radio"/> Prevents certain activities.</p> <p>5. When worse? <input type="radio"/> In the morning hours. <input type="radio"/> In the afternoon hours. <input checked="" type="radio"/> In the evening hours. <input type="radio"/> At bedtime.</p>	
<p>4th Symptom - right temporal headache complaint</p> <p>1. Has complaint <input type="radio"/> ...improved a bit? <input type="radio"/> ...improved a lot? <input checked="" type="radio"/> ...gotten a bit worse? <input type="radio"/> ...gotten a lot worse?</p> <p>2. Pain Scale Enter the 0 to 10 figure from the patient here. 2</p> <p>3. Frequency <input type="radio"/> Under 25% of awake time. <input checked="" type="radio"/> 25% to 50% of awake time. <input type="radio"/> 51% to 75% of awake time. <input type="radio"/> 76% to all of awake time.</p> <p>4. Intensity <input type="radio"/> Not affecting activities. <input type="radio"/> Some affect on activities. <input checked="" type="radio"/> Seriously affects activities. <input type="radio"/> Prevents certain activities.</p> <p>5. When worse? <input checked="" type="radio"/> In the morning hours. <input type="radio"/> In the afternoon hours. <input type="radio"/> In the evening hours. <input type="radio"/> At bedtime.</p>	
<p>5th Symptom - forearm pain</p> <p>1. Has complaint <input type="radio"/> ...improved a bit? <input type="radio"/> ...improved a lot? <input checked="" type="radio"/> ...gotten a bit worse? <input type="radio"/> ...gotten a lot worse?</p> <p>2. Pain Scale Enter the 0 to 10 figure from the patient here. 7</p> <p>3. Frequency <input type="radio"/> Under 25% of awake time. <input checked="" type="radio"/> 25% to 50% of awake time. <input type="radio"/> 51% to 75% of awake time. <input type="radio"/> 76% to all of awake time.</p> <p>4. Intensity <input type="radio"/> Not affecting activities. <input type="radio"/> Some affect on activities. <input checked="" type="radio"/> Seriously affects activities. <input type="radio"/> Prevents certain activities.</p> <p>5. When worse? <input type="radio"/> In the morning hours. <input checked="" type="radio"/> In the afternoon hours. <input type="radio"/> In the evening hours. <input type="radio"/> At bedtime.</p>	
<p>6th Symptom - abdominal pain</p> <p>1. Has complaint <input type="radio"/> ...improved a bit? <input type="radio"/> ...improved a lot? <input checked="" type="radio"/> ...gotten a bit worse? <input type="radio"/> ...gotten a lot worse?</p> <p>2. Pain Scale Enter the 0 to 10 figure from the patient here. 4</p> <p>3. Frequency <input type="radio"/> Under 25% of awake time. <input checked="" type="radio"/> 25% to 50% of awake time. <input type="radio"/> 51% to 75% of awake time. <input type="radio"/> 76% to all of awake time.</p> <p>4. Intensity <input type="radio"/> Not affecting activities. <input type="radio"/> Some affect on activities. <input checked="" type="radio"/> Seriously affects activities. <input type="radio"/> Prevents certain activities.</p> <p>5. When worse? <input type="radio"/> In the morning hours. <input type="radio"/> In the afternoon hours. <input checked="" type="radio"/> In the evening hours. <input type="radio"/> At bedtime.</p>	
<p>7th Symptom - chest pain</p> <p>1. Has complaint <input type="radio"/> ...improved a bit? <input checked="" type="radio"/> ...improved a lot? <input type="radio"/> ...gotten a bit worse? <input type="radio"/> ...gotten a lot worse?</p> <p>2. Pain Scale Enter the 0 to 10 figure from the patient here. 4</p> <p>3. Frequency <input type="radio"/> Under 25% of awake time. <input type="radio"/> 25% to 50% of awake time. <input checked="" type="radio"/> 51% to 75% of awake time. <input type="radio"/> 76% to all of awake time.</p> <p>4. Intensity <input type="radio"/> Not affecting activities. <input type="radio"/> Some affect on activities. <input checked="" type="radio"/> Seriously affects activities. <input type="radio"/> Prevents certain activities.</p> <p>5. When worse? <input type="radio"/> In the morning hours. <input type="radio"/> In the afternoon hours. <input type="radio"/> In the evening hours. <input checked="" type="radio"/> At bedtime.</p>	
<p>8th Symptom - buttock pain</p> <p>1. Has complaint <input type="radio"/> ...improved a bit? <input type="radio"/> ...improved a lot? <input checked="" type="radio"/> ...gotten a bit worse? <input type="radio"/> ...gotten a lot worse?</p> <p>2. Pain Scale Enter the 0 to 10 figure from the patient here. 2</p> <p>3. Frequency <input type="radio"/> Under 25% of awake time. <input checked="" type="radio"/> 25% to 50% of awake time. <input type="radio"/> 51% to 75% of awake time. <input type="radio"/> 76% to all of awake time.</p> <p>4. Intensity <input type="radio"/> Not affecting activities. <input type="radio"/> Some affect on activities. <input checked="" type="radio"/> Seriously affects activities. <input type="radio"/> Prevents certain activities.</p> <p>5. When worse? <input type="radio"/> In the morning hours. <input type="radio"/> In the afternoon hours. <input checked="" type="radio"/> In the evening hours. <input type="radio"/> At bedtime.</p>	
<p>9th Symptom - jaw pain</p> <p>1. Has complaint <input type="radio"/> ...improved a bit? <input type="radio"/> ...improved a lot? <input checked="" type="radio"/> ...gotten a bit worse? <input type="radio"/> ...gotten a lot worse?</p> <p>2. Pain Scale Enter the 0 to 10 figure from the patient here. 2</p> <p>3. Frequency <input type="radio"/> Under 25% of awake time. <input checked="" type="radio"/> 25% to 50% of awake time. <input type="radio"/> 51% to 75% of awake time. <input type="radio"/> 76% to all of awake time.</p> <p>4. Intensity <input checked="" type="radio"/> Not affecting activities. <input type="radio"/> Some affect on activities. <input type="radio"/> Seriously affects activities. <input type="radio"/> Prevents certain activities.</p> <p>5. When worse? <input type="radio"/> In the morning hours. <input type="radio"/> In the afternoon hours. <input type="radio"/> In the evening hours. <input checked="" type="radio"/> At bedtime.</p>	

Additional Subjective Details - (For Doctor's Use Only)
 You can use this space to add any additional information (not covered above), that the doctor would like to include. AutoCodes

SDasfdk/lj sdsldj fl'asd jfasdf jasd! sjdfl;asdj fl;asd j l fj sdsd sdjl fsdlk fjasdl;f jasd;l fjasdl;fjasdl;kfjsd fl l sdsld lsdfl lsd jlt;sd fjsdlk fjsdlfjsdlj sl fjsdlj sdl.

Objective Short Form Screen for SOAP Notes

Objective Evaluation Short Form - The Current Chart is Adams, Raymond - Visit # 1 - Exam Date 1/21/2004

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SOAP - Subjective Complaints SOAP - Objective Testing SOAP - Old Objective Short Form SOAP - Assessment, Current Treatment & Future Care Plan

Click this Button to fill in this screen with the data from the Last Visit. Copy Last Visit's Data Click this Button to Clear This Screen of Data. Clear All Data from This Screen

Range of Motion Short Form
 Passive Active Enter additional ROM data here.
 PROM AROM in the Cervical Thoracic Lumbar spine(s), was within normal limits.
 PROM AROM was slightly decreased in the C T L region(s) with pain spasm
 PROM AROM is moderately decreased in the C T L region(s) with pain spasm Autocodes

Palpation Evaluation Short Form
 Palpation revealed: 1. Tenderness 3. Trigger Points 5. Malpositions in the C T L Spine(s)
 2. Hypertonicity 4. Subluxations 6. Articular Fixations

In each area below check off one or more boxes to indicate the area(s) of difficulty. Then, utilizing the Palpation Scale and/or Modalities List, enter the applicable items to show your Palpation Findings and/or what Modalities you utilized to remedy the patient's difficulties discovered in your Palpation and other testing.

Spine Palpation Area 1
Palpation Findings
2,f2,m1
Modalities Applied
AT15,MS15,WH1

Spine Palpation Area 2
Palpation Findings
Modalities Applied

Spine Palpation Area 3
Palpation Findings
Modalities Applied

Spine Palpation Area 4
Palpation Findings
Modalities Applied

Palpation Scale
Upper & Lower Extremities Palpation
 Choose from the pull-down or type in the area being palpated into box 1, e.g. "left ankle", then use Palpation Scale in Box 2

1	2
1	2
1	2
1	2
1	2
1	2
1	2
1	2
1	2
1	2

Additional Palpation Findings AutoCodes
 More palpation asdfjksdl kfsdlkf jsdifjkd lfkjsjdklsj asdlj flj sfdki jsfdlkj sdlk jfjsjd lkjd lsdjflkskj sdl.
 Other Objective Findings AutoCodes

Modality List
Today's Modalities Applied to Other Areas
 General Cervical Area
 General Thoracic Area
 General Lumbar Area

Choose from the pull-down or type in the area being treated into box 1, e.g. "left ankle", then use Modality List in Box 2)

1	2
1	2
1	2
1	2
1	2
1	2
1	2
1	2
1	2
1	2

Use the Modalities List here for any non-specific areas.
 GP60,IFL,MS30,MW
 Additional Modality Information AutoCodes
 Treatment sdlkjsd lfasd lfasdjf asjdfjksdajfas dljfas dljas dlj sdfasjdfklsajd flasjdl asjdfklsajdl asdjfksdl.

Old Objective Short Form (RM600) for SOAP Notes

Patient's Assessment and Future Care Plan - The Current Chart is Adams, Raymond - Visit # 1 - Exam Date 1/21/2004

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[SOAP - Subjective Complaints](#)
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Click this Button to Clear out this Screen. [Clear All Data from This Screen](#)

Range of Motion Short Form

Passive ROM **Active ROM**

PROM AROM in the Cervical Thoracic Lumbar spine(s), was within normal limits.

PROM AROM was slightly decreased in the C T L region(s) with pain spasm

PROM AROM is moderately decreased in the C T L region(s) with pain spasm

Enter additional ROM data here. **AutoCodes**

Palpation Evaluation Short Form

Palpation revealed: 1. Tenderness 2. Hypertonicity 3. Trigger Points 4. Subluxations 5. Malpositions 6. Articular Fixations in the C T L Spine(s)

Today's Palpation Findings (Use this "Palpation Scale" button, to fill in all boxes below.) **Palpation Scale**

	Left	Right	Bilateral	Mid	All		Left	Right	Bilateral	Mid	All		Left	Right	Bilateral	Mid	All		
Upper Cervical						WNL	Uppr. Thor.						WNL	Uppr. Lumb.					
Mid Cervical						WNL	Mid. Thor.						WNL	Mid Lumb.					
Lower Cervical						WNL	Lowr. Thor.						WNL	Lowr. Lumb.					

Use this section with the "Palpation Scale" Button above, if you want to refer to specific individual vertebral levels.

C-1 C-2 C-3 J2 C-4 J2 C-5 C-6 C-7 L-1 L-2 L-3 L-4 L-5

T-1 T-2 T-3 T-4 T-5 T-6 T-7 T-8 T-9 T-10 T-11 T-12

S1 Sacrum L. Ilium R. Ilium Pelvis Coccyx

Others (click on or type in other areas in 1st box, e.g. "left ankle", & use Palp. Scale in 2nd box)

1 <input type="text"/>	2 <input type="text"/>	1 <input type="text"/>	2 <input type="text"/>	1 <input type="text"/>	2 <input type="text"/>
1 <input type="text"/>	2 <input type="text"/>	1 <input type="text"/>	2 <input type="text"/>	1 <input type="text"/>	2 <input type="text"/>

Additional Palpation Findings **AutoCodes**
 More palpation asdfjksdl kfsdlkf jsdlfjksd lfkjsdlkjsj asdlj
 flj sfdkl jsfdlkj sdlk jfsjkd lkjd lsdjflskj sdl.
 Other Objective Findings **AutoCodes**

Today's Modalities (Use this "Modality List" button, to fill in the boxes below.) **Modality List**

	Left	Right	Bilateral	Mid	All		Left	Right	Bilateral	Mid	All		Left	Right	Bilateral	Mid	All						
Cervical Region						Upper Cervical						Upper Thor.						Upper Lumb.					
Thoracic Region						Mid Cervical						Mid Thoracic						Mid Lumb.					
Lumbar Region						Lower Cervical						Lower Thor.						Lower Lumb.					

Use this section with the "Modality List" Button, if you want to refer to the treatment of specific individual levels.

C-1 C-2 C-3 C-4 C-5 C-6 C-7 L-1 L-2 L-3 L-4 L-5

T-1 T-2 T-3 T-4 T-5 T-6 T-7 T-8 T-9 T-10 T-11 T-12

S1 Sacrum L. Ilium R. Ilium Pelvis Coccyx

Others (click on or type in other areas in 1st box, & use Modality List Items in the 2nd box)

1 <input type="text"/>	2 <input type="text"/>	1 <input type="text"/>	2 <input type="text"/>	1 <input type="text"/>	2 <input type="text"/>
1 <input type="text"/>	2 <input type="text"/>	1 <input type="text"/>	2 <input type="text"/>	1 <input type="text"/>	2 <input type="text"/>

Use the Modalities List here for non-specific areas.
 GP60,IFL,MS30,MW
 Additional Modality Data **AutoCodes**
 Treatment sdlkjsd lfasd lf asjdfis dajfas djlfas dljas dljf
 sdfasjdfllkasjd flasjdl asjdlkjas dljf asdlj sdlk.