PATIENT INFORMATION

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Telephone _____ Social Security No. _____ Driver's License No. _____

Age _____ Birthdate _____ ☐ Male ☐ Female Marriage Status: M S W D No. Children _____

Occupation _____ Employer _____ Years Employed _____

Employer's Address _____ Work Phone _____

Spouse's Name _____ Occupation _____ Employer _____

Person responsible for this account _____ Referred by _____

INSURANCE INFORMATION

☐ Worker's Comp ☐ Private Pay ☐ Group Ins. ☐ Medicare ☐ Other _____

Date of injury _____ (Check one) ☐ Passenger ☐ Driver ☐ Pedestrian Other _____

Did this accident occur during work hours? (Workers' Compensation) ☐ Yes ☐ No

Was employer notified? ☐ Yes ☐ No Date & time notified _____

AUTO INSURANCE (Medical Payment)

a. **PRIMARY INSURANCE CARRIER** (Car patient was in) _____

Insured's name (car owner) _____ Phone No. _____

Billing address _____

Policy No. _____ Claim No. _____ Contact _____

Insured's date of birth _____ Soc. Sec. No. _____

b. **SECONDARY INSURANCE CARRIER** (Patient's car or one owned by relative or household member)

_____ Relation to patient _____

Insured's name _____ Phone No. _____

Billing Address _____

Policy No. _____ Claim No. _____ Contact _____

Insured's date of birth _____ Soc. Sec. No. _____

c. **UNINSURED MOTORIST** (Applies if other car is responsible and other car is a "hit and run" or uninsured).

☐ Hit and Run ☐ Adverse care uninsured

Available insurance (Patient's car or insurance from relative or household member)

Insured's name _____ Date of birth _____

Phone No. _____ Relation to patient _____

Insurance Company _____ Phone No. _____

Address _____

Policy No. _____ Claim No. _____ Contact _____

HEALTH INSURANCE INFORMATION

Patient's Name _____ Date of birth _____

Insurance Carrier _____

☐ Individual (Policy No.) _____ ☐ Group No. _____ Group name _____

Are you covered by Medicare? ☐ Yes ☐ No Medi-Cal? ☐ Yes ☐ No

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	DATE	DATE
HEIGHT		
WEIGHT		
R - B/P		
L - B/P		

VISUAL INSPECTION	L	R	L	R
Head Tilt				
Head Rotation				
High Shoulder				
High Ilia				

EXTREMITY MEASUREMENT				
4" above elbow				
3" below elbow				
7" above patella				
4" below patella				

DYNAMOMETER	L	R	L	R

CERVICAL ROM					
Flexion	60				
Extension	50				
L Rotation	80				
R Rotation	80				
L - Lat Flexion	40				
R - Lat Flexion	40				

THORACO-LUMBAR ROM					
Flexion	90				
Extension	30				
L Rotation	30				
R Rotation	30				
L - Lat Flexion	35				
R - Lat Flexion	35				

NEUROLOGICAL				
Biceps				
Triceps				
Brachioradialis				
Patellar				
Achilles				
Finger to Nose				
Wycks Balance				
Heel Walk				
Toe Walk				
Heel to Shin				
Rhomberg				

CERVICAL ORTHOPEDIC				
Vertebral Basilar				
Allens				
Edens				
Wright				
Halstead				
Cervical Compression				
Cervical Distraction				
Shoulder Distraction				
Soto Hall				
Valsalva				

P = Pain T = Tender N = Numb S = Spasm E = Edema

LUMBO-PELVIC ORTHOPEDIC				
Straight Leg Raise				
Braggard				
Fabere				
Hibb				
Ely				
Gaenslen				
Fajersziajn				
Goldthwaite				
Minor Sign				
Thomas				

CRANIAL NERVES				
1 Olfactory				
2 Occ & Light				
3, 4, 6 Eye Movement				
5 Sen & Taste				
7 Smile				
8 Acoustic				
9 Gag, Taste				
10 Voc. Swallow				
11 Shrug				
12 Tongue Movement				

MUSCLE TESTING	DATE		DATE	
Infraspinatus				
Supraspinatus				
Deltoid (A,M,P)				
Latissimus Dorsi				
Biceps				
Triceps				
Brachioradialis				
SUPINE				
Sartorious				
Psoas				
Quad Fem				
Peronis Longus				
Tibilias Ant.				
Pec Major				
Pec Minor				
Trapezious (U,M,L)				
SCM				
Neck Flexors				
PRONE				
Piriformis				
Glut Max				
Glut Med				
TFL				
Hamstrings				
Gastrocnemius				
Teres Major				
Teres Minor				
Neck Extensors				
Subscapularis				

S = Spastic F = Flacid N = Neurologic

TRIGGER POINT
LOCATION _____

MOTOR POINT
LOCATION _____

COMPLAINT 1 _____ **2** _____

1) Site _____

Severity _____

Better/Worse _____

Radiation _____

2) Site _____

Severity _____

Better/Worse _____

Radiation _____

PRESENT DIAGNOSIS _____

PRESENT TREATMENT PLAN _____

SPECIAL CONSIDERATIONS _____

X-RAY FINDINGS

GENERAL SPINAL DATA _____

CERVICAL SPINE _____

THORACIC SPINE _____

LUMBAR SPINE _____

SPECIAL NOTES _____

LISTINGS

EXAM	1	2
OCC		
C 1		
2		
3		
4		
5		
6		
7		
D 1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
L 1		
2		
3		
4		
5		
Sac		
Lil		
Ril		

FREQUENCY OF TREATMENT

_____ x/week for _____ wks

_____ x/week for _____ wks

_____ x/week for _____ wks

DISABILITY

☐ Total ☐ Temporary

FROM _____ TO _____

FROM _____ TO _____

FROM _____ TO _____

PATIENT'S PROGRESS RECORD

PATIENT'S NAME ____

DATE			DR. INIT.	SUBSEQUENT VISITS, FINDINGS AND REMARKS	PT. INIT.
MO.	DAY	YR.			