Healthy Life CHIROPRACTIC

Neuromuscular Re-Education Intake Form

______ Hot Stone ______ Cold Stone **Office Use Only** MT initials note completed: _______________
Appointment Time: _____:_____ Start Time: _____: _____ Adjustment: *Before*: ______ *After*: _____ (or) *No Adjustment*: _______
Is the patient currently under care as a result of an auto injury: ______Yes (or) __X__ No Massage Only: ____Yes (or) ____ No
Date of Injury: ________/________/___________ Date of Last Adjustment: ________/________/___________

Date: ________ /_________ /___________

Essential Oil Added: Yes ____ or No ____
Essential Oil Used:_________________________

Name: ______________________________________ Date of Birth: ______ /______ /__________

Address: ______________________________________ City: __________________ State: _______ Zip: _____________

Phone: _______ - _________ - __________ Email: ____

Emergency Contact: ____ Phone: _______ - ________ - __________

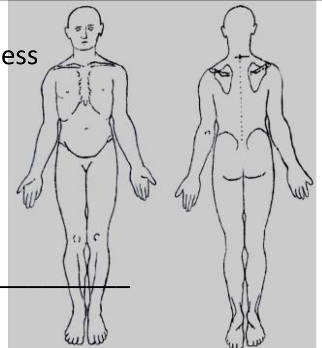
FORM MUST BE COMPLETED FOR YOUR THERAPIST BEFORE YOUR SESSION

1. **Do you bruise easily? ( ) Yes ( ) No**
2. **Would you prefer the therapist to explain what is going on?**
   ( ) Throughout the session ( ) The last 5 minutes of the session ( ) I prefer NO talking during the entire session
3. **What type of pressure do you prefer?** ***(Please keep in mind, more is not necessarily better.)***
   ( ) Light ( ) Moderate ( ) Heavy (*If pressure needs to be changed please tell your therapist.)*

List Chief Area of Complaint – Severe to Moderate Complaint **See next page for additional areas of complaint**

1. **List only ONE area of complaint:** ____

Please mark anatomy man



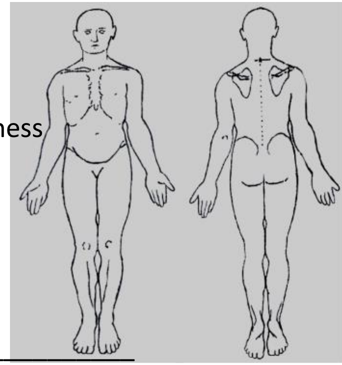
Intensity: (1-4 being mild, 5-7 being moderate, and 8-10 being severe)
Scale of: ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) 6 ( ) 7 ( ) 8 ( ) 9 ( ) 10
Symptoms: ( ) Sharp Pain ( ) Aching ( ) Tingling ( ) Stabbing ( ) Burning ( ) Dull ( ) Stiffness
( ) Numbness ( ) Swelling ( ) Headaches ( ) Decreased mobility/range of motion
Frequency: ( ) Constant (76% -100% of the time) ( ) Frequent (51% -75% of the time)
( ) Occasional (26% -50% of the time) ( ) Intermittent (0% -25% of the time)
Does it radiate: ( ) Yes ( ) No. If yes, where _________________________________
What caused it: ( ) Repetitive movement ( ) Lifting ( ) Exercising ( ) Sitting
( ) Re-Injured old injury ( ) Fall ( ) If other, then what: _______________________________________
Symptom has been present for: ( ) less than 1 week ( ) 1-2 weeks ( ) 3-4 weeks
( ) 1-3 months ( ) 3-6 months ( ) If other, then what: ____
Pain pattern: Better in the: ( ) Morning ( ) Mid-day ( ) Evening; **Worse in the:** ( ) Morning
( ) Mid-day ( ) Evening ( ) Consistent ( ) If other, then what: _____________________________________
What makes it worse: ( ) Bending ( ) Lifting ( ) Sitting ( ) Standing ( ) Running ( ) Driving ( ) Reaching
( ) Looking down ( ) Exercising ( ) If other, then what:____
What makes it better: ( ) Chiropractic Care ( ) Neuromuscular Re-Education ( ) Physical Therapy ( ) Ice
( ) Heat ( ) Resting ( ) Stretching ( ) Exercising ( ) If other, then what: ______________________________
What treatment have you received for your symptoms? ( ) Chiropractic ( ) Neuromuscular Re-Education
( ) Muscle Stim ( ) Cold Laser ( ) Physical Therapy ( ) Acupuncture ( ) Dry Needling ( ) Medication
( ) Surgery ( ) If other, then what: ____
Daily Activities/Hobbies that aggravate the area of complaint: ( ) Walking ( ) Standing ( ) Exercise ( ) Cross fit
( ) Yard work ( ) Housework ( ) Cycling ( ) Running ( ) If other, then what: ______________________________
Restrictions of daily activities/hobbies: How long before it starts hurting: (hour) ( ) ½ ( ) 1 ( ) 2 ( ) 6 ( ) 12 ( ) 24
( ) Varies on activities/hobbies

PLEASE MAKE SURE YOUR CELL PHONE IS OFF OR ON SILENT DURING YOUR THERAPY SESSION

Office Use Only
30 Min: _________ 1 Hour: ________ Hour & Half: _________ 2 Hours: _________ Package Visit: ___________
Arrival time: _____:_____ Therapist: _____________ Freq: 1xWk 2xM 1xM (or)____________ CA: _______ Time:_____:_____

Name: ____

Please mark anatomy man



List Second Area of Complaint – Moderate to Mild Complaint

2. **List only <u>ONE</u> area of complaint:** ______________________________________
   Intensity: (1-4 being mild, 5-7 being moderate, and 8-10 being severe)
   Scale of: ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) 6 ( ) 7 ( ) 8 ( ) 9 ( ) 10
   Symptoms: ( ) Sharp Pain ( ) Aching ( ) Tingling ( ) Stabbing ( ) Burning ( ) Dull ( ) Stiffness ( ) Numbness ( ) Swelling ( ) Headaches ( ) Decreased mobility/range of motion
   Frequency: ( ) Constant (76% -100% of the time) ( ) Frequent (51% -75% of the time) ( ) Occasional (26% -50% of the time) ( ) Intermittent (0% -25% of the time)
   Does it radiate: ( ) Yes ( ) No. If yes, where ______________________________
   What caused it: ( ) Repetitive movement ( ) Lifting ( ) Exercising ( ) Sitting ( ) Re-Injured old injury ( ) Fall ( ) If other, then what: ____________________________________
   Symptom has been present for: ( ) less than 1 week ( ) 1-2 weeks ( ) 3-4 weeks ( ) 1-3 months ( ) 3-6 months ( ) If other, then what: ____
   Pain pattern: Better in the: ( ) Morning ( ) Mid-day ( ) Evening; **Worse in the:** ( ) Morning ( ) Mid-day ( ) Evening ( ) Consistent ( ) If other, then what: __________________________________
   What makes it worse: ( ) Bending ( ) Lifting ( ) Sitting ( ) Standing ( ) Running ( ) Driving ( ) Reaching ( ) Looking down ( ) Exercising ( ) If other, then what:____
   What makes it better: ( ) Chiropractic Care ( ) Neuromuscular Re-Education ( ) Physical Therapy ( ) Ice ( ) Heat ( ) Resting ( ) Stretching ( ) Exercising ( ) If other, then what: ____________________________
   What treatment have you received for your symptoms? ( ) Chiropractic ( ) Neuromuscular Re-Education ( ) Muscle Stim ( ) Cold Laser ( ) Physical Therapy ( ) Acupuncture ( ) Dry Needling ( ) Medication ( ) Surgery ( ) If other, then what: ____
   Daily Activities/Hobbies that aggravate the area of complaint: ( ) Walking ( ) Standing ( ) Exercise ( ) Cross fit ( ) Yard work ( ) Housework ( ) Cycling ( ) Running ( ) If other, then what: _____________________________
   Restrictions of daily activities/hobbies: How long before it starts hurting: (hour) ( ) ½ ( ) 1 ( ) 2 ( ) 6 ( ) 12 ( ) 24 ( ) Varies on activities/hobbies

Please check any condition that applies to you ***(This is used in case Cold Laser is performed during your session):***
( ) Cancer ( ) Pacemaker ( ) Epileptic Seizures

Have you had a stroke*: ( ) Yes ( ) No*
If yes, when did you have the stroke: ____

Women Only: Are you currently pregnant? ( ) Yes ( ) No If yes, how many weeks: ____________________________

<u>Medicine History:</u> (***For a safe and effective session your therapist needs to know if you are on the following medication.)***

Are you currently taking any of the following medication?
( ) Blood Thinner ( ) Diabetic Medication ( ) Cholesterol Medication ( ) Corticosteroid
( ) Pain Medication ( ) Anti-depressant ( ) Blood Pressure Medication

Please list names and dosages of current medications:
~Medicine: ____________________ a day ____ MG: _____ ~Medicine: __________________ a day ____ MG: ______
~Medicine: ____________________ a day ____ MG: _____ ~Medicine: __________________ a day ____ MG:______

Is there anything about your **<u>health history, surgical history, any injuries, accidents and/or illnesses</u>** affecting you that you think your therapist should know before your session? ( ) Yes ( ) No If yes, please explain:

____

Patient Name: ___________________________________

PLEASE ANSWER THE QUESTIONS BELOW TO THE BEST OF YOUR KNOWLEDGE:

Do you have any difficulty lying on your ( ) front ( ) back ( ) side ( ) none

Do you have any allergies or sensitive to anything such as oils, scents, etc.? ( ) Yes ( ) No,
If yes, please explain____

Are you currently under medical supervision? ( ) Yes ( ) No
If yes, please explain: ____

Please check any condition listed below that applies to you:

( ) Fibromyalgia
( ) TMJ ( ) Right ( ) Left
( ) Carpal Tunnel Syndrome
( ) Right ( ) Left ( ) Both
( ) Tennis Elbow ( ) Right ( ) Left ( ) Both
( ) Pregnancy, how many weeks? ____
( ) Contagious skin condition
Type: _________________________
Location: ______________________
( ) Open sores or wounds
Location: ______________________
( ) Easy bruising
( ) Cancer ( ) Current ( ) In remission
Type: _________________________
Location: ___________________
( ) Diabetes
( ) Decreased sensation
Location: ______________________

( ) Swelling of a vein in the leg(s) or arm(s)
Location: __________________________
( ) Deep Vein Thrombosis/Blood clots
Location: __________________________
( ) Joint disorder
Location: __________________________
( ) Rheumatoid Arthritis
Location: __________________________
( ) Osteoarthritis Location: ____________________
( ) Tendonitis Location: ______________________
( ) Artificial joint Location: ___________________
( ) Osteoporosis Location: _____________________
( ) Varicose Veins Location: ___________________
( ) Epilepsy
Most recent episode: ________________
( ) Headaches
Frequency: ________________________
( ) Migraines Frequency: ________________________

( ) Heart condition
Type: _______________________
( ) Circulatory disorder
Type: _______________________
( ) High Blood Pressure
Controlled ( ) Yes ( ) No
( ) Low Blood Pressure
Controlled ( ) Yes ( ) No
( ) Current fever
( ) Asthma
( ) Recent accident or injury
Date: ________/_______/______
Explain: _________________________
____
____
____
____

What is your occupation: ____

Patient Consent Form

Draping will be used during the session – only the area being worked on will be uncovered.

Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent(s) or legal guardian for any client under the age of 17.

I, ____ **(print name)** understand that the therapy session I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that neuromuscular therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that the therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because neuromuscular therapy should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I also understand that the License Therapist reserves the right to refuse to perform neuromuscular therapy on anyone whom he/she deems to have a condition for which therapy is contraindicated**. If at any time during the session the therapist is uncomfortable with your behavior during the session the therapist reserves the right to end the session and the full time allotted will be billed to you.**

X____ _______/_________/________
Signature of Patient and/or Legal Guardian of Patient Date

X____ _______/_________/_________
Signature of Therapist Date

This and all forms are the property of Healthy Life Chiropractic ~ 2753 E. Highway 34, Ste 1 ~ Newnan, GA 30265 ~ 770-252-3661

Pt.#: _______

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HEALTHY LIFE CHIROPRACTIC STATEMENT OF PATIENT OFFICE POLICIES

Welcome to Healthy Life Chiropractic. Please read and sign this policy statement below. Our staff will be happy to assist you with any questions or concerns you may have. Our focus is for you, our patient and your family to have an extraordinarily positive experience. We believe that a clear definition of your prescription of care to regaining your health, setting measurable goals (Activities of Daily Living) and maintaining your health is critical. Following your prescription of care is vital to your success. We also believe that clear definition of office policies will allow you, the patient; and Healthy Life Chiropractic to concentrate on the big issue—**REGAINING AND MAINTAINING YOUR HEALTH**.

Your prescription of care is based on medical necessity as deemed appropriate by the Doctor of Chiropractic. As such, Re-evaluations are completed in this office to measure progress of care and medical necessity, regardless of insurance coverage, insurance carrier or no insurance coverage. If you are out of care for three (3) or greater months, a re-evaluation will be required to correctly assess a possible change in adjusting technique and/or an underlying health issue that would change your prescription of care. It is the policy of this office to re-evaluate through x-ray every two (2) years, to correctly assess a possible change in adjusting technique and/or an underlying health issue that would change your prescription of care. Any outside products are NOT allowed to be brought into the office for use during any service. This is due to other patients and/or employees having allergies and sensitivities. Only in-house products may be added to the service. Please notify a staff member in the event you have a sensitivity or allergy. **Patient/Legal Guardian Initials: _____________**

CHIROPRACTIC, NEW PATIENT, RE-EVALUATION, RE-ESTABLISH EVALUATION, ROF, COLD LASER, HEALTH RESPONSE TESTING (HRT), HBOT, DECOMPRESSION, EAR CONING & IONIC FOOTBATH APPOINTMENT CANCELLATION POLICY & APPOINTMENT REMINDERS:

Appointments have been scheduled for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine. Regardless of how many appointments are scheduled for you each week, please note that it is the *frequency* of visits that counts, and not the days. We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. If you have any questions regarding our office policy or your appointments, please do not hesitate to speak to the front desk assistant. We require 24-hour notice for any cancelled or rescheduled appointments. **Failure to show for any scheduled appointment without a 24-hour notification will result in a $50.00 charge payable by YOU, not your insurance company**. You are expected to re-schedule missed appointments in order to comply with your prescribed treatment plan. Please keep in mind that re-scheduling an appointment is always subject to availability. **Our office utilizes email and/or text messaging to remind you of upcoming appointments. Not confirming your appointment via call, text, or email, does not constitute a canceled appointment. Please refrain from using a cell phone in all areas of the office. If necessary to take a call, please step outside after informing the front desk. Patient/Legal Guardian Initials: _____________**

NEUROMUSCULAR RE-EDUCATION (MASSAGE) APPOINTMENT CANCELLATION POLICY & APPOINTMENT REMINDERS:

Appointments have been scheduled for your convenience. Children are not allowed to be in the room during your appointment. **We require a 24-hour notice for any canceled or re-scheduled appointments. Failure to show for an appointment without notification will result in a $75.00 (1 hour) $112.50 (1.5 hour) or $150.00 (2 hour) charge payable by YOU, *not your insurance company*. Not confirming your appointment via call, text, or email, does not constitute a canceled appointment.** If you are more than 20 minutes late for your neuromuscular re-education (massage) appointment you will be subject to continuing with the service based on appointment book availability, possibly rescheduling, or charged the **above** cancelation fee schedule. Should you have a scheduled massage appointment and are unable to complete "your entire scheduled time" you are still financially responsible for the total scheduled time allocated for you during your scheduled appointment. Should you be billing insurance for this visit, your insurance company is not responsible for cancelation fees or time not utilized by the patient, so therefore, the lost scheduled time is payable by you. If at any time during the session the therapist is uncomfortable with your behavior the therapist reserves the right to end the session and the full time allotted will be billed to you. **It is unethical and illegal for this office to bill your insurance company for services not rendered on the date in question. Our office utilizes email and/or text messaging to remind you of upcoming appointments for Neuromuscular Re-Education (Massage). Not confirming your appointment via call, text, or email, does not constitute a canceled appointment. Please refrain from using a cell phone in all areas of the office. If necessary to take a call, please step outside after informing the front desk. Patient/Legal Guardian Initials: _____________**

PRODUCTS, SERVICES AND PACKAGES SOLD IN THE OFFICE:

All products that are sold in the office have a **NO RETURN/NON-REFUNDABLE POLICY**. (Supplements, Pillows, Oils, CBD, Neck Collars, Foam Rollers, ETC.) Orthotics can be returned to the company under Foot Levelers guidelines. Once a particular service package is purchased, they are **NON-REFUNDABLE AND NON-TRANSFERABLE** and may not be applied to any other purchases and/or services within the office. This applies to all services and packages. Packages cannot be split between patients, there is a **ONE year expiration** on package cards and gift certificates. Should you terminate your care and/or move from the region with package visits or services untendered, please request a refund and allow thirty (30) from date of request for refund to be processed. **ALL SALES ARE FINAL. Patient/Legal Guardian Initials: _____________**

Continue on the next page

APPOINTMENT REMINDERS:

Healthy Life Chiropractic uses a appointment reminder (text and email) program for our patient reminders, sales, promotions and important notifications. You will receive a welcome letter via text message and/or e-mail for you to opt-in or opt-out. If you choose to opt-out, you will not be able to receive appointment reminders. **Please remember this can result in a NO SHOW FEE if you opt-out and do not show up for your appointmen**ts. **Patient/Legal Guardian Initials: _____________**

FINANCIAL RESPONSIBILITY WITH AND WITHOUT INSURANCE:

Charges for treatment are due at the time the service is provided or a product is ordered. Please be aware that some services in this office are not covered by ANY insurance carrier and are excluded from some insurance carriers. This office, to the best of our knowledge, informs our patients of their insurance coverage. However, financial responsibility for services rendered rests with the patient regardless of any insurance coverage. It must be understood that your medical insurance is a contract between ***you*** and ***your*** insurance carrier. The benefits quoted by your insurance carrier are not a guarantee of payment and are subject to review based on the terms of your individual contract. All insurance coverage quotes are merely estimates based on the information quoted by your insurance carrier. All services rendered are ultimately your (the patient's or patient's legal guardian's) financial responsibility and are payable in full. Services quoted and received by you may be quoted as covered but are denied (non-covered) by your insurance carrier will be assigned to you. ***Any balance is due within 30 days of notice***. ***Please note that you are responsible for knowing the limitations of your coverage.*** It is not our policy to enter into a dispute between you and your insurance carrier over any unpaid portion of your bill. Most insurance companies process claims within 30 days of receipt. Should your insurance company send you a check for services rendered that should have been paid to Healthy Life Chiropractic you will have 10 days to pay Healthy Life Chiropractic for those services. If you have an HRA (Health Reimbursement Account) account, it is your responsibility to keep up with your available HRA funds. If you have an HSA (Health Savings Account) you are responsible for your balance at the time of services rendered in the office. **Patient/Legal Guardian Initials: _____________**

STATEMENTS:

In an effort to reduce healthcare costs, it is the policy of HLC to mail as few statements as possible. HLC will email statements to the email address on file. Should an email not be provided, and a paper statement has to be sent by postal mail, *each mailed invoice will be assessed with a $2.00 paper statement fee*. If a patient balance is incurred, responsible parties are encouraged to mail the payment directly to HLC upon receiving the EOB (explanation of benefits) from their insurance company. If 30 days have passed after the first generated statement and it is necessary for HLC to mail a second statement (because no payment has been received) a flat interest charge of 12% of the balance, but not less than $5.00 will be added to the account. **If no payment is received within 10 business days after the mail date of the second statement, the account will be reviewed with a 10-day demand letter certified mail to the address on file. If payment is not received following the 10-day period, the account will be turned over to the collection agency or filed with the county court system in the county you reside in. All collection fees and court fees are paid by the patient**. **ALL ACCOUNTS TURNED OVER TO THE COLLECTION AGENCY WILL ALSO BE RESPONSIBLE FOR THE COLLECTIONS AGENCY FEE OF 40% OF THE BALANCE OWED. Patient/Legal Guardian Initials: _____________**

RETURNED CHECKS:

There will be a **$50.00 fee** imposed for all checks returned to this office. All returned checks must be taken care of within 10 days of receipt. Any unpaid amounts after 10 days will be referred to our collection agency or filed with the county court system in the county you reside in. **Patient/Legal Guardian Initials: _____________**

VOLUNTARY TERMINATION OF CARE:

It is the policy of this office that should you choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be **immediately due and payable**; regardless of your balance is from Self-Pay visits, Insurance visits and/or the UCCAFF agreement. Should you be in a UCCAFF agreement, your charges will be reversed to regular cost and the balance will be due in full. **Patient/Legal Guardian Initials: _____________**

PATIENT RECORDS REQUEST:

Any records/documents requested from the office requires ten (10) business days for completion. We do not send any records/documents electronically. Fees may apply. Should you need FMLA, and/or Work-Related forms filled out, fees will apply for these forms and are payable by the patient at the time the form is requested to be filled out by the Doctor. Please allow ten (10) business days for this form to be completed. This office does not file disability ratings. This requires a specific certification that HLC does not have. **Patient/Legal Guardian Initials: _________**

I, the Patient (or) Parent/Legal Guardian undersigned below, have read "Statement of Patient Office Policies" (above) and I agree to abide by these policies.

Patient Name (Printed): X____ **Date:** ________ / _________ /__________

Patient (or) Parent/Legal Guardian Signature: X____

Therapist Use Only

Time Started: ________:_______
Time Ended: ________:________

Patient Name: ___________________________________

Notes regarding visit: ____

NEUROMUSCULAR RE-EDUCATION:

01 Cervical (Scalene, Levator Scapula, SCM, Occipitals, Splenius Capitus, Upper Traps, Upper Erectors)	**12 Arms** (Deltoids, Biceps, Triceps, Brachialis, Brachioradialis, Flexors, Extensors)
02 Upper Back, Thoracic (Mid-Trapezius, Rhomboids, Mid-Erectors, Serreatus Posterior Superior)	**13 Hands**
03 Mid Back (Mid-Erectors, Latissimus Dorsi, Low-Trapezuis, Longissimus Thoracis, Spinalis Thoracis)	**14 Elbows**
04 Low Back, Lumbar (QL's, IL's, Low-Erectors, Latissimus Dorsi, Obliques, Serratus Post/Infer)	**15 Head, Sinus & Headaches** (Frontalis, Temporalis, Occipitals)
05 Rotator Cuff (Supraspinatus, Subscapularis, Infraspinatus, Teres Minor)	**16 TMJ** (Temporomandibular Joint, Masseter)
06 Shoulders (Pecs, Deltoids, Teres Miror, Teres Major, Supraspiratus)	**17 Inguinal Ligament** (Pectineus, Gracilis, Adductor Magnus, Longus Brevis
07 Hip (Tensor Fascia Latae, Piriformis, Gluteus Min/Med/Max, Psoas Maj, Exturnus, Sup/Inf Gemelli)	**18 IT Bands**
08 Quads (Rectus Femoris, Vastus Lateralis, Medialis, Intermedius, Sartoris)	**19 Chest** (Pectoralis Major and Pectoralis Minor)
09 Hamstrings (Biceps Femoris, Semitendinosus, & Semimembranosus)	**20 Abdominals** (Trans Abdom., Rectus Abdom. & Int, Ext, Oblique)
10 Lower Legs (Peroneals, Gastrocnemius, Soleus, Patella Ligament)	**21 Psoas** (Major & Minor)
11 Knees	**22 Feet & Plantar of the feet**

1. Region: 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 Time: 10 15 20 30
   ( ) PNF/ ↑ Functional Self Care/ ↑Mobility **( ) Pin/Stretch ↑ Functional Self Care/ ↑Mobility**
   ( ) ART/ ↑Functional Self Care/↑Mobility ( ) Contract/Relax Stretch/ ↑Functional Self Care/↑Mobility
2. Region: 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 Time: 10 15 20 30
   ( ) PNF/ ↑ Functional Self Care/ ↑Mobility **( ) Pin/Stretch ↑ Functional Self Care/ ↑Mobility**
   ( ) ART/ ↑Functional Self Care/↑Mobility ( ) Contract/Relax Stretch/ ↑Functional Self Care/↑Mobility
3. Region: 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 Time: 10 15 20 30
   ( ) PNF/ ↑ Functional Self Care/ ↑Mobility **( ) Pin/Stretch ↑ Functional Self Care/ ↑Mobility**
   ( ) ART/ ↑Functional Self Care/↑Mobility ( ) Contract/Relax Stretch/ ↑Functional Self Care/↑Mobility

Total Time: : 10 15 20 30 45 60 90 **(minimum 30 minutes)**

THERAPEUTIC EXERCISE:

01 Cervical (Scalene, Levator Scapula, SCM, Occipitals, Splenius Capitus, Upper Traps, Upper Erectors)	**12 Arms** (Deltoids, Biceps, Triceps, Brachialis, Brachioradialis, Flexors, Extensors)
02 Upper Back, Thoracic (Mid-Trapezius, Rhomboids, Mid-Erectors, Serreatus Posterior Superior)	**13 Hands**
03 Mid Back (Mid-Erectors, Latissimus Dorsi, Low-Trapezuis, Longissimus Thoracis, Spinalis Thoracis)	**14 Elbows**
04 Low Back, Lumbar (QL's, IL's, Low-Erectors, Latissimus Dorsi, Obliques, Serratus Post/Infer)	**15 Head, Sinus & Headaches** (Frontalis, Temporalis, Occipitals)
05 Rotator Cuff (Supraspinatus, Subscapularis, Infraspinatus, Teres Minor)	**16 TMJ** (Temporomandibular Joint, Masseter)
06 Shoulders (Pecs, Deltoids, Teres Miror, Teres Major, Supraspiratus)	**17 Inguinal Ligament** (Pectineus, Gracilis, Adductor Magnus, Longus Brevis
07 Hip (Tensor Fascia Latae, Piriformis, Gluteus Min/Med/Max, Psoas Maj, Exturnus, Sup/Inf Gemelli)	**18 IT Bands**
08 Quads (Rectus Femoris, Vastus Lateralis, Medialis, Intermedius, Sartoris)	**19 Chest** (Pectoralis Major and Pectoralis Minor)
09 Hamstrings (Biceps Femoris, Semitendinosus, & Semimembranosus)	**20 Abdominals** (Trans Abdom., Rectus Abdom. & Int, Ext, Oblique)
10 Lower Legs (Peroneals, Gastrocnemius, Soleus, Patella Ligament)	**21 Psoas** (Major & Minor)
11 Knees	**22 Feet & Plantar of the feet**

1. Region: 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 Time: 8 12 10 15 16
   ( ) Isokinetic Exercise / Goal: ↑ROM ( ) Stabilization Exercises / Goal: ↑Flexibility
2. Region: 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 Time: 8 12 10 15 16
   ( ) Isokinetic Exercise / Goal: ↑ROM ( ) Stabilization Exercises / Goal: ↑Flexibility
3. **Total Time:** _ 8 12 14 16 31 __ **(minimum 16 minutes)**

ADDITIONAL MODALITIES: ***( ) Neck ( ) Shoulders ( ) Arms / Hands ( ) Mid Back ( ) Low Back*** **( ) Hips *(*) Legs ( ) Other ______________**

( ) **Deep Tissue** ( ) Swedish ( ) **Trigger Point** ( ) Reflexology (x) **NMT** ( ) Myofascial Release ( ) Friction ( ) **Traction**
( ) Lymphatic Drainage ( ) Compressions ( ) Cupping ( ) Cold Stones ( ) Hot Stones ( ) Ice Pack ( ) Heat Pack
( ) **Stretches** ( ) Passive Exercise ( ) Active Exercise

Total Time: ___8 12 14 _____ **(maximum 14 minutes)**

COLD LASER AREA: ____________________________ ______ Time: _________________ (minimum 10 minutes)

HOME PLAN:
(x) Drink plenty of water
( ) Ice ( ) Heat: ***( ) Neck ( ) Shoulders ( ) Upper Back ( ) Mid Back ( ) Low Back*** **( ) Hips *(*) Legs ( ) Other ____________________________**
( ) Stretching: ***( ) Neck ( ) Shoulders ( ) Arms / Hands ( ) Low Back*** **( ) Hips *(*) Legs ( ) Other ____________________________________**
( ) Exercises: ***( ) Neck ( ) Shoulders ( ) Arms / Hands ( ) Low Back*** **( ) Hips *(*) Legs ( ) Other ____________________________________**
( ) Strengthening: ____
( ) Foam Roller: _____________________________________ ( ) Tennis Ball: ____
( ) Products Recommended: ____

Pt.#: ________

Therapist Use Only

Patient Assessments:

03. The patient is showing favorable response to treatment and reports a reduction of the severity of symptoms.
05. The patient's assessment indicates the need for treatment continuing at the same interval.
07. Subjectively, the patient stated that the course of conservative Chiropractic care and therapeutic case management has helped their condition.
08. The patient has demonstrated a positive attitude with regard to their recovery. The patient has complied very well to the treatment plan designed for them.
18. The patient indicated that the therapies are reducing their symptoms.

Therapist Assessments:

04. The patient has suffered an exacerbation of the condition.
14. The patient should respond favorably to conservative case management. This will initially consist of passive care followed by a combination of passive and active care. Their level of symptoms should decrease, and their level of function should increase.
15. Since the patient began treatment at this clinic, they have responded favorably to conservative case management. Their level of symptoms is continuing to decrease, and their level of function is continuing to increase. The prognosis remains favorable at this time.
20. The patient has made a generalized response to care obtaining progressive relief of symptoms, however sporadically.
22. The patient is progressing favorably under conservative case management; however, the duties required of the patient at their place of employment are a repeated source of aggravations. This could lead to a future episode of exacerbation.
27. The patient has responded favorably to the conservative Chiropractic care and therapeutic case management. The patient is strongly advised to continue with the current course of treatment.
28. The patient has responded favorably to the active, aggressive, supervised rehabilitation program specifically designed for their particular condition based on their activities of daily living and work requirements. The patient has achieved a functional recovery as their progress has reached a plateau and they will be conditionally released from care as provided that no further aggravations, irritations, and exacerbations occur.
30. The patient has responded favorably to Chiropractic therapy, but such progress has been slow. Subjectively, their level of symptoms is about the same, but objective findings demonstrate a mild improvement.
53. The first component of the patient's injury was the muscles. This protective mechanism is set up to reduce and restrict motion. Once these spasms begin to abate and motion came back, it uncovered the biomechanical joint instability that was underlying the spasm. This instability places undue pressure on nerves and causes an overstretching of the joint ligamentous elements.

Work Comments:

01. The patient should be precluded from work today.
02. The patient was given specific instructions regarding preclusions to lifting.
33. The patient continues to perform the duties required of them by their employment position.

Home Comments:

06. The patient has been instructed in performing active range of motion stretching within a pain-free zone. As motion increases, the patient is to increase the stretch, up to but not beyond, the new pain free zone. These exercises should be performed three times daily.
09. The patient continues to perform the specific home exercise program designed for them by this office based on their work requirements and activities of daily living.

Miscellaneous Comments:

AGADL: The patient experienced and/or notices aggravation of symptoms due to/with activities of daily living. **PTTXW: Patient tolerated treatment well.**
FBWL: The patient reported they felt better when they left our clinic. **Int.D:** The patient reported the intensity of the symptom(s) has decreased.
MN: Neuromuscular Re-Education is used to increase local blood flow, accelerate elimination of metabolic waste products, reduce spasticity, and assess muscle tone.
THER CARE: The patient is receiving therapeutic care directed to reduce symptomology and improve function through correction of spinal misalignments and treatment of para-spinal tissues. This is performed in an attempt to enable the patient to perform normal daily activities with minimal reoccurrences. Treatment is considered necessary to establish a stationary status at maximum improvement. This may include treatment that relieves exacerbation/aggravation/reoccurrences of symptoms.

Goals: Area One:	**Area Two:**
Area 1 of complaint: ______________________	**Area 2 of complaint**: ______________________
Short term goal:______________________	Short term goal:______________________
Long term goal:______________________	Long term goal:______________________

Suboccipitals
Splenius Capitus
Levator Scapulae
Supraspinatus
Teres Minor
Rhomboids
Infraspinatus
Teres Major
Subscapulari
Triceps
Trapezi
Latissimus Dorsi
Erectors Spinae
Iliocostalis Lumborum
Extensors of Forearm
Quadratus Lumborum
Obliques
Hands
Piriformi
Glutes
Hamstrings
Knees
Gracilis
Gastrocnemius
Soleus
Ankles
Plantar of Feet

Temporali
Frontali
Sternocleidomastoid
TMJ
Trapezius
Scalene
Deltoids
Pecs
Biceps
Serratus Anterior
Elbows
Brachioradiali
Abdominal
Tensor Fascia Latae
Psoas
Flexors of Forearms
Iliacus
Adductor Brevis
Pectine
Adductor Longus
IT Band
Sartori
Quads
Tibialis
Adductor Magnus
Pereneals

Legend
X Adhesion
≡ Hypertonicity
↔ Long
○ Pain
● Tender Point
/ Elevation
Inflammation
Numbness
Short
Trigger Point

M – *Mild*
(Scale: 1-2)
M/MD –
Mild/Mild Moderate
(Scale: 3-4)
MD – *Moderate*
(Scale: 5-6)
MS – *Moderate-Severe*
(Scale: 7-8)
S- *Severe*
(Scale: 9-10)

This and all forms are the property of Healthy Life Chiropractic ~ 2753 E. Highway 34, Ste 1 ~ Newnan, GA 30265 ~ 770-252-3661

Pt.#: ________