CHIROFIT™

SOAP NOTE

PATIENT NAME: John Doe DATE: 8-4-17 VISIT # 8

ULTRASOUND	INTERFERENTIAL / PREMOD	REHAB EXERCISES / TPT	TRACTION
Area: C UT MT (L) SI	1.5/ 1.0 w/cm2	Area: C (UT) MT (L) SI	Time: 10 min	Intensity: To Patient Tolerance	Area: (C) UT MT SH (L) SI	Type: Floor Propio (Stretches) Fitball Tubing	Time: 30 min	Area: C UT MT (L) SI	Time: 20 min
8 min									

OTHER: | [X] ICE / HEAT Time (min): 15 (C) UT MT L SI | [X] PNF Time (min): 10 C UT MT L SI EXT

Spine

TECHNIQUE (choose one)

(Diversified)
Gonstead
Activator
Thompson Drop
Flexion Distraction
Other

Occ	
C1	X, S, P
C2	
C3	
C4	
C5	X, TN
C6	
C7	
T1	
T2	
T3	
T4	
T5	X
T6	X
T7	
T8	
T9	
T10	
T11	
T12	
L1	
L2	S, TP
L3	
L4	
L5	X, S, P
SI	

L | (R) Shoulder
L | R Rib
L | R Elbow
L | R Wrist
(L) | R Hip
L | R Knee
L | R Ankle
Other

SUBJECTIVE

Patient comments: About the Same / Better / Worse / (Slightly Better) / Slightly Worse

Quality of Life: Patient states having a slight noticeable decrease in the intensity of his neck pain.

OBJECTIVE

Myospasms (use the folllowing number ranges: 1-mild 2-moderate 3-severe)

Suboccipital (Paracervical) 2 SCM (Trapezins) 2 Rhomboids Parathoracic (Paralumbar) 1 Piriformis

Tenderness (use the folllowing number ranges: 1-mild 2-moderate 3-severe)

Suboccipital Paracervical 2 SCM Trapezins 2 Rhomboids Parathoracic Paralumbar 1 Piriformis

ROM: (Cervical) Thoracic (Lumbar) Extremeties

ASSESSMENT

Per DX / (As Expected) / Exacerbation / Adt'l:

PLAN

PER TX PLAN (See Current A&P Form) / EX-I Instruction / EX-II Instruction / (Adt'l:)

Visits: (M) T (W) Th (F) S Daily (3x wk) 2x wk 1x wk Visits / Other below:

Additional Notes: Continue with at Home Care plan of Stretching and Strengthening Exercises for neck and low back.

Work Restrictions/Comments: No Work / (Light Duties) (describe below)

No strenuous pushing, pulling, or lifting weight that exceeds 15 pounds for the next two weeks

Billing Codes (CPT)

1-2 Regions	98940
3-4 Regions	(98941)
EXT / Modifier 51	(98943)

Therapy Codes (ICD10)

97140	/units	97010	1 /units
97110	1 /units	97012	2 /units
97112	/units	97014	1 /units
97035	2 /units		

[X] New DX Codes (add below)

M25.571

[X] SEE DIAGNOSIS PAGE

USE this for RE-EVAL or NEW codes

Sample Doctor DC.
CHIROPRACTOR NAME

Sample Doctor DC.
CHIROPRACTOR SIGNATURE

8-4-17
DATE

CHIROFIT™

623.773.2000

PHYSICAL, NEUROLOGICAL, & ORTHOPEDIC EXAM

PATIENT NAME: John Doe DATE: 8-4-17

HEIGHT: 5'11"

WEIGHT: 218 lbs.

AGE: 26

BLOOD PRESSURE: 124/84 mmHG

PULSE: 64 BPM

SENSORY (PINWHEEL/COTTON):

UPPER: WNL

LOWER: ↓ (R)

NECK EXAM

ROM	NORMAL	EXAM	NOTES:
Flexion	50	35	P, I, S
Extension	60	45	P, I, S
L. Rot.	80	70	P, I
R. Rot.	80	65	P, I
L. Lat. Flex	45	30	P, I, S
R. Lat. Flex	45	25	P, I, S

NECK ORTHOPEDIC TESTS

	L	R	Notes:
Valsalva	—	—	
Soto Hall			DNP
Cerv Compress	+	+	P @ C2-3
Cerv Distraction	—	—	
Max Cerv Comp	+	+	P @ C2-3
Shoulder Depress	+	—	P @ C6, Spasm
George's	—	—	

LOW BACK EXAM

ROM	NORMAL	EXAM	NOTES:
Flexion	60	WNL	NO PAIN
Extension	25	↓	P, I, S
L. Rot.	20	WNL	NO PAIN
R. Rot.	20	WNL	NO PAIN
L. Lat. Flex	25	↓	P, I, S
R. Lat. Flex	25	↓	P, I

LOW BACK ORTHOPEDIC TESTS

	L	R	Notes:
Elys	—	—	
Kemp's	+	+	P @ SIJ's
Nachlas	—	—	
Yeomans			DNP DUE to pain
Braggard's	—	—	
Minors Sign	—	—	
Faber Patrick	—	—	
BL Leg Raise	+	+	P @ L4-5
Single Leg Raise	+	—	P @ L4-5
Bechterew's Test	—	—	
Heel Walk	—	—	
Toe Walk	—	—	
Dejerine Triad	—	—	

Occ TP's w/ Spasms-2
C1 X, S, P
C2
C3 X, S-2, P
C4
C5
C6
C7
T1
T2
T3 X, TN
T4 X
T5
T6
T7
T8 S, P
T9
T10
T11
T12
L1
L2
L3
L4 Spasms w/ muscle guarding
L5 X, S, P
S/Ps
Coccyx

REFLEXES

5=Sustained Clonus 4=Clonus 3=Hyper
2=Normal 1=Diminished 0=Absent

		L	R
Biceps	C5-6	2	2
Triceps	C6-7	2	3
Radial	C6-7-8-T1	2	2
Patellar	L2-3-4	2	1
Achilles	L5-S1-2	2	2

MUSCLE TESTING

5=Normal 4=Good 3=Fair 2=Poor
1=Trace 0=No Contraction

	L	R
Quad	4	4
Deltoid	5	5
Wrist Ext	5	5
Wrist Flex	4	5
Hamstring	5	5
Ext Hal Lon	5	5

PCS

(Attention)	(Memory)	1/2
Dizziness	Apathy	
(Headache)	(Fatigue)	3/7
Anxiousness	Insomnia	
Change in Personality		

PTSD & ASD

Flashbacks	Nightmares	1/3
Exposure Distress		
Avoidance Behavior		1/1
Anger	(Insomnia)	2/5
Hypervigilance	Irritability	
(Concentration)		

MISC FINDINGS

INITIAL DIAGNOSIS

S13.4XXA, M99.01
S33.5XXA, M99.03
M62.838

"OR"

☒ SEE DIAGNOSIS PAGE

☒ Initial Exam 99203
☐ Re-Eval 99213

Sample Doctor DC
CHIROPRACTOR NAME

Sample Doctor DC.
CHIROPRACTOR SIGNATURE

8-4-17
DATE

CHIROFIT™

623.773.2000

PHYSICAL, NEUROLOGICAL, & ORTHOPEDIC EXAM

PATIENT NAME: John Doe DATE: 8-4-17

☒ SEE NECK/LOW BACK PNO

HEIGHT: ' "

WEIGHT: lbs.

AGE:

BLOOD PRESSURE: / mmHG

PULSE: BPM

SENSORY (PINWHEEL/COTTON):

UPPER:

LOWER:

SHOULDER EXAM

ROM	NORMAL	L	R	NOTES:
Flexion	180	WNL	WNL	
Extension	45	WNL	WNL	
Abduction	180	↓	WNL	P, I, S
Adduction	45	WNL	WNL	
Int. Rot.	55	↓	WNL	P, I, S
Ext. Rot.	45	WNL	WNL	

SHOULDER ORTHOPEDIC TESTS	+/-	
Dugas Test	−	
Supraspinatus Test	+	Weak (R)
Apley's Scratch Test	−	
Anterior Apprehension Test	−	
Posterior Apprehension Test	−	

OR"

ELBOW EXAM

ROM	NORMAL	L	R	NOTES:
Flexion	135+	135	130	
Extension	0-5	3	2	
Supination	90	90	60	P @ Radial Head
Pronation	90	80	90	

ELBOW ORTHOPEDIC TESTS	+/-	
Mill's Test	+	P @ (L) lat Epicondyle
Cozen's Test	−	
Abduction Stress Test	−	
Adduction Stress Test	−	

WRIST EXAM

ROM	NORMAL	L	R	NOTES:
Flexion	80			
Extension	70			
Ulnar Dev.	30			
Radial Dev.	20			

WRIST ORTHOPEDIC TESTS	+/-	
Phalen's Test		
Tinel's Wrist Test		
Weight Bearing Sign		

INITIAL DIAGNOSIS

M25.512, M99.07

"OR"

☒ SEE DIAGNOSIS PAGE

HIP EXAM

ROM	NORMAL	L	R	NOTES:
Flexion	135			
Extension	15			
Abduction	45			
Adduction	25			
Int. Rot.	35			
Ext. Rot.	45			

HIP ORTHOPEDIC TESTS	+/-	Notes:
Ely's Test		
Gaenslen's Test		
Hibb's Test		
Nachla's Test		
Ober's Test		
Patrick's Test		
Trendelenburg Test		
Yeoman's Test		

KNEE EXAM

ROM	NORMAL	L	R	NOTES:
Flexion	135			
Extension	0			

KNEE ORTHOPEDIC TESTS	+/-	
Drawer Sign		
McIntosh Test		
Bounce Home Test		
Apley's Distraction Test		
Apley's Compression Test		
Abduction Stress (Varus)		
Abduction Stress (Valgus)		
Patellar Grinding Test		
Patellar Ballotment Test		
Patellar Apprehension Test		

ANKLE EXAM

ROM	NORMAL	L	R	NOTES:
D. Flexion	20			
P. Flexion	50			
Inversion	5			
Eversion	5			

ANKLE ORTHOPEDIC TESTS	+/-	
Tinel's Foot Sign		
Drawer's Foot Sign		
Medial Stability Test		
Lateral Stability Test		

REFLEXES

5=Sustained Clonus 4=Clonus 3=Hyper
2=Normal 1=Diminished 0=Absent

Biceps	C5-6	L	R
Triceps	C6-7	L	R
Radial	C6-7-8-T1	L	R
Patellar	L2-3-4	L	R
Achilles	L5-S1-2	L	R

☒ SEE NECK/LOW BACK PNO

MUSCLE TESTING

5=Normal 4=Good 3=Fair 2=Poor
1=Trace 0=No Contraction

Quad	L	R
Deltoid	L	R
Wrist Ext	L	R
Wrist Flex	L	R
Hamstring	L	R
Ext Hal Lon	L	R

☒ SEE NECK/LOW BACK PNO

OTHER:

NOTES:

** USE "SEE NECK/LOW BACK PNO" IF HT, WT, BP, AGE, REFLEXES, AND MUSCLE TESTING ARE RECORDED ON NECK AND LOW BACK PNO SHEET.

☒ Initial Exam 99203

☐ Re-Eval 99213

Sample Doctor DC
CHIROPRACTOR NAME

Sample Doctor DC
CHIROPRACTOR SIGNATURE

8-4-17
DATE

CHIROFIT™

ASSESSMENT PLAN

☒ INITIAL EXAM ☐ RE-EVALUATION ☐ OTHER _____

PATIENT NAME: John Doe DATE: 8-4-17 VISIT # 1

ASSESSMENT:

Injury Date: 7-27-17 ☒ Complaints consistent with exam finding & M.O.I. ☐ Possibility of delayed onset of symptoms

Presenting Stage: (Acute/Unresolved Inflammatory) Sub-Acute Strengthening Restoration of Normal Function Released

Response to care (re-evaluation): (As Expected) Better Than Expected Slower Than Expected

IF RE-EVAL

BASED UPON HIS RESULTS, THE PROGNOSIS FOR THIS PATIENT IS GOOD, PATIENT HAS BEEN COMPLIANT.

TREATMENT PLAN:

1. (CMT) / PMMTP to C / T / (L) HMP/Cold 10 Min. EMS (80-pps/tet) 10 Min. US (1.5/____w/cm2) ____Min.
INF (80-150Hz) ____Min. IST ____Min.

2. Extremity (CMT) / PMMTP:

Shoulder	L	X	R		ANT. SUBLUX	Wrist	L		R		
Elbow	L		R			Knee	L		R		
Ankle	L		R			Hip	L		R		

3. Stretching (EX-1) / Strengthening (EX-2): EX-1: NECK AND LOW BACK, EX-2: CORE STRENGTHENING

4. Treatment Goals: (Reduce Pain) (Reduce Spasm) Reduce Trigger Point (Increase ROM)

5. Treatment Frequency: (3x/4 Weeks) 2x/4 Weeks 1x/4 Weeks Other: _____

6. Home RX: (Rest) (Ice) Heat Skip Rest

7. Work Restrictions: LIGHT DUTIES: NO STRENUOUS PUSHING, PULLING, OR LIFTING WEIGHT THAT EXCEEDS 15 POUNDS

8. Referral / Consult: AZMED FOR INITIAL EXAM

Notes: PATIENT RECEIVED ICE INSTRUCTIONS TO ICE THE AREAS OF COMPLAINT FOR 20 MINUTES, TAKING CARE TO INSULATE BARE SKIN FROM DIRECT CONTACT WITH THE ICE BAG TO AVOID SKIN BURNS.

Diagnosis Codes: S13.4XXA, S23.3XXA, S33.5XXA, M25.512, M99.07, M62.838

"OR" → ☒ SEE DIAGNOSIS PAGE

Sample Doctor DC — CHIROPRACTOR NAME

Sample Doctor DC — CHIROPRACTOR SIGNATURE

8-4-17 — DATE

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SOAP NOTE CONT.

PATIENT NAME: John Doe DATE: 8-4-17 VISIT # 8

USE this PAGE For Additional NOTES or Findings IF NEEDED

Sample Doctor DC
CHIROPRACTOR NAME

Sample Doctor DC
CHIROPRACTOR SIGNATURE

8-4-17
DATE

CHIROFIT

AZMEDINJURY
REFERRAL FORM

PATIENT NAME: John Doe DATE: 8-4-17

PATIENT PHONE #: (123)-456-7891 PATIENT EMAL: JDOE@Gmail.com

DATE OF BIRTH: 5-4-82 ATTORNEY: LERNER + ROW DATE OF INJURY: 7-27-17

SERVICES

- [x] Initial Medical Evaluation / Consultation
- [x] Motor Vehicle Accident
- [ ] Worker's Comp
- [ ] Spinal Injection / Procedure Evaluation
- [ ] Trigger Point Injections
- [ ] Narcotic Management
- [ ] Topical Pain Creams
- [ ] Joint Injection
- [ ] Gabapentin / Lyrica
- [ ] Medication TX
- [ ] NSAIDS
- [ ] Muscle Relaxers
- [ ] Opiods

CHIEF COMPLAINT / COMMENTS

(L) Shoulder Pain, Lower Back Pain

*** OR IF NEED For REFERRAL to SPECIALIST ***

REFERRAL to ORTHOPEDIC For (L) Shoulder injury. MRI taken on 8-2-17 with SimonMED

REFERRING PROVIDER CONTACT

PROVIDER NAME: Sample Doctor DC PROVIDER SIGNATURE (REQUIRED): Sample Doctor DC

EMAIL: DrSample@chirofitgroup.com OFFICE NAME: Chirofit - Phoenix

EMAIL REFERRAL TO **SCHEDULING@CHIROFITGROUP.COM ONLY**

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ICD-10 DIAGNOSIS CODES

☒ INITIAL EXAM ☐ RE-EVALUATION

PATIENT NAME: John Doe DOI: 7-27-17 PROVIDER: Sample Doctor DC DATE: 8-4-17

CERVICAL

- ☐ **F07.81** Post Concussional Syndrome
- ☐ **G44.1** Vascular headache, not elsewhere classified
- ☐ **G44.209** Tension-type headache, unspecified, not intractable
- ☐ **G44.311** Acute post-traumatic headache, intractable
- ☐ **G44.319** Acute post-traumatic headache, not intractable
- ☐ **M24.20** Disorder of Ligament
- ☐ **M50.20** Displacement of cervical intervertebral disc without myelopathy (disorder)
- ☐ **M54.12** Radiculopathy, cervical region
- ☒ **M99.01** Cervical Segmental and Somatic Dysfunction 5
- ☒ **S 13.4xxA** Sprain of Ligaments of The Cervical Spine, Initial Encounter 2

LUMBAR

- ☐ **M24.20** Disorder of Ligament
- ☐ **M51.26** Displacement of lumbar intervertebral disc without myelopathy (disorder)
- ☐ **M54.16** Radiculopathy, lumbar region
- ☐ **M54.41** Lumbar Pain with Right sided Sciatica Pain
- ☐ **M54.42** Lumbar Pain with Left sided Sciatica Pain
- ☐ **M54.5** Lumbar Pain
- ☒ **M99.03** Lumbar Segmental and Somatic Dysfunction 6
- ☒ **S33.5xxA** Sprain of Ligaments of the Lumbar Spine, initial encounter 1

THORACIC

- ☐ **M24.20** Disorder of Ligament
- ☐ **M51.24** Displacement of thoracic intervertebral disc without myelopathy (disorder)
- ☐ **M54.14** Radiculopathy, thoracic region
- ☐ **M54.6** Thoracic Pain
- ☐ **M99.02** Thoracic Segmental and Somatic Dysfunction
- ☒ **M99.08** Rib Segmental and Somatic Dysfunction 7
- ☒ **S23.3xxA** Sprain of Ligaments of the Thoracic Spine, initial encounter 3
- ☐ **S23.41XA** Rib Sprain

SHOULDER

- ☒ **M25.511** Right Shoulder Pain 4
- ☐ **M25.512** Left Shoulder Pain
- ☐ **M99.07** Upper Extremity Segmental and Somatic Dysfunction
- ☐ **S40.021A** Contusion of right upper arm, initial encounter
- ☐ **S40.022A** Contusion of left upper arm, initial encounter
- ☐ **S43.421A** Sprain of rotator cuff on right, initial encounter
- ☐ **S43.422A** Sprain of rotator cuff on left, initial encounter
- ☐ **S43.51XA** Sprain of right acromioclavicular joint, initial encounter
- ☐ **S43.52XA** Sprain of left acromioclavicular joint, initial encounter
- ☐ **S46.011A** Strain of rotator cuff muscles on right, initial encounter
- ☐ **S46.012A** Strain of rotator cuff muscles on left, initial encounter

KNEE

- ☐ **M25.561** Pain Right Knee
- ☐ **M25.562** Pain Left Knee
- ☐ **S80.02XA** Contusion of left knee
- ☐ **S80.01 XA** Contusion of right knee
- ☐ **S83.511A** Sprain of anterior cruciate ligament right knee, initial encounter
- ☐ **S83.512A** Sprain of anterior cruciate ligament left knee, initial encounter
- ☐ **S83.91 XA** Sprain of unspecified site of right knee, initial encounter
- ☐ **S83.92XA** Sprain of unspecified site of left knee, initial encounter

FOOT

- ☐ **M79.671** Pain Right Foot
- ☐ **M79.672** Pain Left Foot

ELBOW

- ☐ **M25.521** Pain Right Elbow
- ☐ **M25.522** Pain Left Elbow
- ☐ **S50.11XA** Contusionof Right Forearm, Initial encounter
- ☐ **S50.12XA** Contusion of Left Forearm, Initial encounter

WRIST

- ☐ **M25.531** Pain Right Wrist
- ☐ **M25.532** Pain Left Wrist
- ☐ **M79.641** Pain in Right Hand
- ☐ **M79.642** Pain in Left Hand
- ☐ **M79.644** Pain in Right Finger
- ☐ **M79.645** Pain in Left Finger
- ☐ **S51.811A** Laceration without foreign body of right forearm, initial encounter
- ☐ **S51.812A** Laceration without foreign body of left forearm, initial encounter
- ☐ **S63.501A** Unspecified sprain of Right Wrist, Initial encounter
- ☐ **S63.502A** Unspecified sprain of Left Wrist, Initial encounter

PELVIS

- ☐ **M99.04** Sacral Segmental and Somatic Dysfunction
- ☐ **M99.05** Pelvic Segmental and Somatic Dysfunction

HIP

- ☐ **M25.551** Pain in Right Hip
- ☐ **M25.552** Pain in Left Hip
- ☐ **M25.651** Stiffness of Right Hip
- ☐ **M25.652** Stiffness of Left Hip
- ☐ **M99.06** Lower Extremity Segmental and Somatic Dysfunction
- ☐ **S70.01XA** Contusion of right hip, initial encounter
- ☐ **S70.02XA** Contusion of left hip, initial encounter
- ☐ **S70.11XA** Contusion of right thigh, initial encounter
- ☐ **S70.12XA** Contusion of left thigh, initial encounter

ANKLE

- ☐ **M25.571** Pain Right Ankle
- ☐ **M25.572** Pain Left Ankle
- ☐ **S93.401A** Sprain of unspecified ligament right ankle, initial encounter
- ☐ **S93.402A** Sprain of unspecified ligament left ankle, initial encounter

MISC

- ☐ **F07.81** Post Concussional Syndrome
- ☐ **M26.62** Bilateral TMJ pain
- ☐ **M99.00** Occipito-Atlantal Segmental and Somatic Dysfunction
- ☐ **S00.83XA** Contusion of other part of head, initial encounter
- ☐ **S03.4XXA** TMJ Sprain, initial encounter
- ☐ **S20.219A** Contusion of chest wall, initial encounter
- ☐ **S30.1XXA** Contusion of abdominal wall
- ☐ **S39.011A** Strain of muscle, fascia and tendon of abdomen, initial encounter
- ☒ **M62.838** Muscle Spasm 8
- ☐ **M79.1** Myalgia
- ☐ USE this space for codes not listed
- ☐
- ☐ ** Please number Diagnosis codes in
- ☐ order of severity by placing a number
- ☐ after code description
- ☐

☒ Initial Exam 99203 ☐ Re-Eval 99213

CHIROFIT™

NEW PATIENT COVER SHEET

INFORMATION:

PATIENT NAME: Jane Doe DATE: 7/8/17

OFFICE LOCATION: Sample doctor

☐ AZMEDINJURY ☒ CHIROPRACTIC

CHECKLIST:

- ☐ DATE OF INJURY 7/2/17
- ☐ PATIENT ZIP CODE 12345
- ☐ PATIENT PHONE 602-111-2345
- ☐ PATIENT EMAIL Janedoe@server.com
- ☐ ATTORNEY INFO / 3RD PARTY INFO Pad law firm
- ☐ ALREADY SEEN WITH/WHERE Az Med & Injury

WORKERS COMP CASE ☒ YES ☐ NO

IF YES, PROVIDE THE FOLLOWING INFORMATION

CLAIM NUMBER: 012345678

INSURANCE: Workers Ins.

ADJUSTER'S NAME: James Doe

EXAMPLE

CHIROFIT

PATIENT INTAKE FORM

Office Location McDowell

Name: Doe Jane N
Nombre LAST FIRST MIDDLE

Age: 22 Date of birth: 7/1/95 Date: 7/7/17
Edad *Fecha de Nacimiento* *Fecha*

Address: 1234 Sierra In
Domicilio

Social Security #: 111-00-1111
Número de Seguro Social

☐ Male ☑ Female
Sexo

City, State, Zip: Phoenix, Az, 85029
Ciudad, Estado, Codigo Postal

Marital Status: ☐ M ☑ S ☐ W ☐ D
Estado Civil

# of Children _____
 # de Ninos

Cell Phone (555) 123-4567
Número de Teléfono Móvil

Work Phone (____) _____
Número de Teléfono Trabajo

Email address: _____
Correo Electrónico

Employer: N/A
Empleadores

Spouse's Name: _____
Esposa/o

Occupation: _____
Ocupación

Spouse's Employer: _____
Empleador del cónyuge

In case of emergency, notify Jerry Doe
Contacto de Emergencia

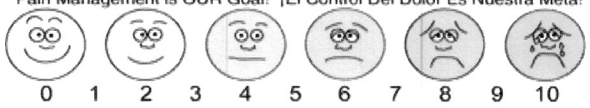
Relationship: father
Relación

Phone (555) 123-4567
Telefono

Current Symptoms: 1. lowerback pain (9) 2. R hip pain (9) 3. _____ 4. _____
Síntomas
5. _____ 6. _____ 7. _____ 8. _____

For each symptom above, rate on a pain scale (1-10)/ Scala de Dolor (1-10) Example: neck pain/ 8

Pain Management is OUR Goal! ¡El Control Del Dolor Es Nuestra Meta!



lowbackpain 9
hip pain 9

When did your symptoms begin? right after car accident.
¿Cuándo comenzó sus síntomas?

In general, what makes your symptoms better? rest
¿En general lo que hace que los síntomas mejor?

In general, what makes your symptoms worse? walking / standing for too long.
En general ¿Qué hace que sus síntomas empeoren?

In general, how would you describe your pain? (ache, burn, dull, sharp, throbbing): Sharp / ache
En general ¿cómo describiría el dolor? (dolor, quemadura, embotado, agudo, pulsátil)

Are your symptoms local or do they travel to another area? (If they travel, to where?) from lower back to right hip.
¿Son los síntomas locales o viajan a otra zona? (Si llegan, a donde?)

Are symptoms; ☐Constant >76% ☑Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% **of your waking hours**
Son síntomas; ☐*Constante > 76%* ☐*Frecuencia 51-75%* ☐*Ocasional 26-50%* ☐*Intermitente < 25%* ***de sus horas de vigilia***

EXAMPLE

CHIROFIT

PATIENT INTAKE FORM

Office Location_____

Chief Complaints/Symptoms:

Since the accident/injury, tell me **ALL symptoms or injuries you have experienced and specifically when each began (write date next to symptom):
***Desde el accidente*, *dígame **TODOS** los síntomas o lesiones que usted ha experimentado y, específicamente cuando comenzaron (Escriba el dia de la fecha junto al síntoma):*

☐ Headache *Dolor de Cabeza*	☑ Middle Back Pain/Stiffness *Dolor en medio de la espalda*	☐ Ears Ring *Oídos sonando*	☐ Any Burns *Quemaduras*
☐ Neck Pain/ Stiffness *Dolor en el cuello/ Rigidez*	☐ Chest/Chest wall Pain *Dolor en el pecho*	☐ Buzzing in Ears *Zumbido en los oídos*	☐ Fainting *Desfallecimiento*
☐ Dizziness *Mareo*	☐ Any Cuts/stitches *Cortadas/Puntadas*	☐ Muscle Spasms *Engarrotamiento Muscular*	☐ Anxiety *Hacienda*
☑ Sleeping Problems *Problemas para dormir*	☐ Bruising Anywhere *Hematoma en cualquier lugar*	☐ Tingling in Legs *Hormigueo en las piernas*	☐ Depression *Depresión*
☐ Blurred Vision *Visión Borrosa*	☐ Tingling in Arms *Cosquilleo en brazos*	☑ Upper/ Lower Leg *Dolor en la pierna superior/ parte baja de la pierna)*	
☑ Lower Back Pain/ Stiffness *Dolor en la parte baja de la espalda/Rigidez*	☐ Sensitivity to Light *Sensibilidad a la luz*	☐ Jaw Pain *Dolor de mandíbula*	☐ Upper/ Lower Arm Pain *Dolor de brazo superior/ el brazo inferior*

☐ Other Symptoms / *Outros Sin Tomas:*

_____

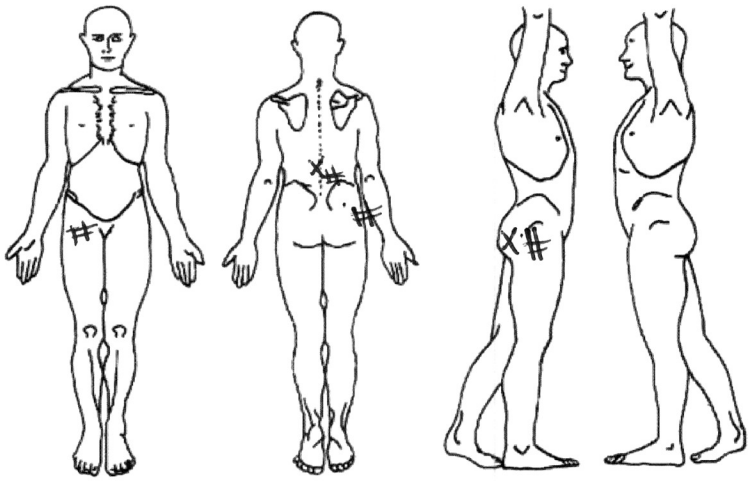
_____

_____

Pain/Symptoms:

On the Body Diagram below, indicate your region of pain using the symbols below:

(X) Sharp – *Agudo*
(+) Numb/Tingling – *Entumecido/Hormigueo*
(#) Dull/ Aching – *Dolorido*
(B) Burning – *Ardor*



EXAMPLE

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CHIROFIT

PATIENT INTAKE FORM

Office Location_____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:
¿TIENES UNA HISTORIA DE CUALQUIERA DE LAS SIGUIENTES ENFERMEDADES?

Tuberculosis ☐ Yes *Tuberculosis*	Lung Disease ☐ Yes *la enfermedad pulmonar*	Gout ☐ Yes *Gota*	Diabetes ☐ Yes *Diabetes*
Kidney Disease ☐ Yes *Enfermedad del riñón*	Stomach/Ulcer ☐ Yes *Sí la úlcera de estómago*	Heart Disease ☐ Yes *La enfermedad cardíaca*	Hepatitis ☐ Yes *Hepatitis*
Sciatica ☐ Yes *Ciática*	Blood Pressure ☐ Yes *La presión arterial*	Transfusion ☐ Yes *La transfusión*	Polio / MS ☐ Yes *La poliomielitis / MS*
Colon Disease ☐ Yes *Enfermedad de colon*	Stroke ☐ Yes *Movimiento*	Cancer ☐ Yes *El cáncer*	Bleeding ☐ Yes *Sangrado*
Paralysis ☐ Yes *Parálisis*	Seizures ☐ Yes *Las convulsiones*	Arthritis ☐ Yes *La artritis*	Asthma ☑ Yes *Asma*
Anemia ☐ Yes *Anemia*	Thyroid Disease ☐ Yes *La enfermedad de tiroides*	Drug Dependence ☐ Yes *La droga dependencia*	AIDS ☐ Yes *SIDA*

Were there any symptoms which you had after the accident/injury that have now resolved? (please list)
¿Donde hay algún síntoma que había tras el accidente que ahora ha resuelto? (por favor, lista)
no

Please list all medications and dosage: **Frequency?** **For What Illness?**
Por favor una lista de todos los medicamentos y dosis: Frecuencia para qué enfermedad?

N/A

List any allergies to medications, foods or other: Penicillin
Lista de alergias a medicamentos, alimentos u otro

Are you pregnant? ☐ Yes ☑ No First day of last menstrual cycle: _____
Está embarazada *Primer día del último ciclo menstrual*

Do you smoke? ☐ Yes ☑ No; How much? _____ Do you drink alcohol? ☐ Yes ☑ No; How much? _____
¿Usted fuma? *¿Usted bebe alcohol?* *¿Cuánto?*

Please list all serious illness: **Month and Year** *(Mes y año)*
Por favor una lista de todas las enfermedades graves

Please list any recent x-rays, lab or other tests: **Date** **Facility/Doctor**
Por favor indique cualquier radiografías recientes, laboratorio u otros exámenes *Fecha* *Servicio/médico*

X-ray day after accident. 7/2/17

EXAMPLE

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CHIROFIT

PATIENT INTAKE FORM

Office Location_____

Date of current accident/injury *(Fecha de accidente actual)*: 7/1/17 **Hour:** 6:00 **AM** ✓ **PM** _____

Specific Location of accident *(Ubicación específica del accidente)*: 1234 yellow road

City *(Ciudad)* Phoenix **County** *(Condado de)*_____

Describe in detail, in your own words, how the accident/injury happened: I was moving
Describir en detalle, en sus propias palabras, cómo sucedió el accidente
over into (a) turning lane, the other driver swerved into my lane and hit my passenger side totaled my right side of car.

AUTOMOBILE/MOTORCYCLE ONLY

In the accident: Were you the ☑ Driver ☐ Passenger ☐ Pedestrian ☐ Other? _____
En el accidente: Eras el ☐ Controlador ☐ Pasajeros ☐ Peatonal

Did your vehicle strike the other vehicle? ☐ Yes ☑ No
¿Su vehículo huelga el otro vehículo? ☐ Si ☐ No

Did the other vehicle strike your car? ☑ Yes ☐ No
¿Hizo el otro vehículo golpear su coche? ☐ Si ☐ No

Were you struck from? ☐ Behind ☐ Front ☐ Driver Side ☑ Passenger Side **Motorcycle Only**: ☐ Left Side ☐ Right Side
Pulsaron de? ☐ Detrás de ☐ Delantero ☐ Del lado del conductor ☐ Lado del pasajero ☐ Lado izquierdo ☐ Lado derecho

Did airbags deploy? ☑ Yes ☐ No
Se abrio la bolsa de segurida de aire? ☐ Si ☐ No

Were traffic citations issued to? ☐ You ☐ Driver of Your Vehicle ☑ Driver of the Other Vehicle ☐ No Citations Given
Se expidieron citaciones de tráfico a? ☐ Se ☐ Conductor de su vehículo ☐ Conductor del otro vehículo ☐ No hay citaciones dado

Was your vehicle heading? ☐ North ☑ South ☐ East ☐ West on Highway (Street/Highway)
Fue el rumbo del vehículo?

Was the other heading? ☐ North ☑ South ☐ East ☐ West on Highway (Street/Highway)
Fue el otro epígrafe?

Have you lost time from work? ☑ Yes ☐ No: If Yes, Dates: 7/2/17 to 7/7/17
Han perdido tiempo de trabajo? ☐ Sí ☐ No: En Caso Afirmativo, Fechas: _____ a _____

Where did you go after the accident? ☑ Hospital ☐ Urgent Care ☐ Home ☐ Work ☐ Other _____
Donde ir después del accidente? ☐ Hospital ☐ Urgencias ☐ Inicio ☐ Trabajo ☐ Otros _____

Were you taken by ambulance? ☑ Yes ☐ No To which hospital? Memorial
Fue tomado por ambulancia? A qué hospital?

Address: 1243 E Memorial Dr. Date of Hospitalization: 7/1/17
Dirección Fecha de hospitalización

EXAMPLE

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CHIROFIT

PATIENT INTAKE FORM

Office Location_____

PLEASE PROVIDE US WITH THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR AUTOMOBILE INSURANCE CARRIER: Gelico
SU COMPAÑÍA DE SEGUROS DE AUTOMÓVIL

Address: 4567 S Saint 10 Telephone: (555)123-4567 Fax: (____)_____
Domicilio *Número de Teléfono*

Claim #: 1234567890 Policy #: 9876543321 Claim Rep: Sam
Número de Reclamo *Número de Póliza* *Representante de*

Med-Pay Benefits: _____ Uninsured (UM) Benefits: _____ Underinsured (UIM) Benefits: _____

Have you signed a selection waiver of benefits? ☐ Yes ☐ No ☐ Unsure
Ha firmado una renuncia de la selección de beneficios? ☐ Sí ☐ No ☐ No está seguro

Are you a full time Student? ☑ Yes ☐ No Do you reside with a relative? ☐ Yes ☑ No
Eres un estudiante a tiempo completo? ☐ Sí ☐ No no vive con un pariente? ☐ Sí ☐ No

2) YOUR HEALTH INSURANCE COMPANY: N/A
SU COMPAÑÍA DE SEGUROS DE SALUD

Address: _____ Insured: _____
Domicilio *Asegurado*

Date of Birth: _____ Policy #: _____ SS#: _____
Fecha de Nacimiento *Número de Póliza* *Número de Seguro Social*

Telephone: (____) _____ Fax: (____) _____
Número de Teléfono

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: State Farm

Address: 8888 30th St. Telephone: (XXX)111-2222 Fax: (____)_____
Domicilio *Número de Teléfono*

Claim #: 0000100000 Policy #: 11101110 Claim Rep: Carl
Número de Reclamo *Número de Póliza* *Representante de Reclamaciones*

4) ATTORNEY: I&R Legal Assistant: Jim
Abogado *Asistente Legal*

Address: 6226 Circle Crt.
Domicilio

Telephone: (XXX) 555-8888 Fax: (____) _____
Número de Teléfono

EXAMPLE

* EXAMPLE *

CHIROFIT

PATIENT INTAKE FORM

Office Location_____

FOR AUTO INJURY PATIENTS ONLY AND DOCTOR'S LIEN

Dear Patient:
It has become standard practice in the Health Care Industry and a requirement of the State of Arizona per Statute 33-931 and 33-932 to file what is known as "Notice and Claim of Health Care Provider Lien". These liens must be recorded with the County Recorder's Office, by law. A copy will be sent to you by certified mail for your records, and will be released when we receive payment in full. A copy of the release will also be sent to you via first class mail.

Please be assured that this is not a lien against you, or your property. This is not a reflection on your integrity and will not be picked up by credit reporting agencies for any reason, as this lien is not against you the patient, but merely a lien for payment from the responsible insurance company for your medical care costs.

At the time of settlement of your case you will receive a check/draft made out jointly to you and the Doctor, at which time you are required to promptly bring the check/draft to our office for disbursement of funds.

If you have an attorney, the check will be made out to you and your attorney. Your attorney must sign an indemnifying agreement with the insurance company to pay any and all liens in full (we do not negotiate to reduce our fees). If for some reason your settlement does not cover the cost of your care, you are personally responsible and agree to pay the balance of the bill in full.

By signing this notice you understand and agree to the above terms.

Patient Name: Jane Doe

Attorney: I & R

Date of Injury: 7/1/17

I hereby authorize and irrevocably direct my attorney, Sam, to pay promptly to CHIROFIT Chiropractic and Physical Therapy and Arizona Medical & Injury, PLLC, from my portion of any proceeds out of any recovery relevant to the action in which he represents me.

Dated: 7/7/17 Signature: _____
Patient/Debtor

The undersigned being the attorney of record for_____
Does hereby agree to observe all the terms of the above and agrees to withhold such sums from settlement, judgement, or verdict as may be necessary to adequately protect CHIROFIT Chiropractic and Physical Therapy and Arizona Medical & Injury, PLLC, and/or their assignor.

Dated: ___/___/___ Signature: _____
Attorney

* EXAMPLE *

EXAMPLE

CHIROFIT

PATIENT INTAKE FORM

Office Location_____

AUTHORIZATION TO REQUEST (AND RELEASE WHEN NECESSARY) MEDICAL RECORDS

Fax#_____

Patient Name Jane Doe

D.O.B 7/1/1995

Date of Injury 7/1/17

I hereby authorize _____to release any information including the intake sheets, diagnosis, labs, x-rays, and records of any treatment rendered to me at this facility.

I also hereby authorize the release TO any appropriate attorney's office and/or healthcare provider to which I may need to be referred to for treatment as a result of this accident.

This consent expires 24 months after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify ARIZONA MEDICAL & INJURY/ CHIROFIT in writing to that effect. I understand that any release, which was made prior to my revocation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

_____ 7/7/17

PATIENT SIGNATURE Date:

PLEASE FAX REQUEST TO 623-776-2813 ASAP

EXAMPLE

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CHIROFIT

PATIENT INTAKE FORM

Office Location_____

ACKNOWLEDGEMENT OF OWNERSHIP / ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE INFORMATION

I hereby acknowledge that by signing this Acknowledgement of Ownership I fully understand that Dr. Scott Stamp DC has ownership interest in CHIROFIT and Arizona Medical & Injury, PLLC and will financially benefit from the procedures being performed on this date.

Should I elect not to accept a referral from one entity to the other, I am hereby informed and understand that I may choose another facility within which I can receive medical services.

I authorize all insurance benefits, unless previously paid by myself, to be paid directly to CHIROFIT and Arizona Medical & Injury, also authorize the release of all information required in the processing of the insurance claim submitted on my behalf. I further authorize the release of any and all medical information deemed necessary for my health care to my referring physician, primary care physician, spouse, children, parents, physician and attorney deemed necessary.

NOTE: If you do not understand any part of this document, please speak to a staff member before signing.

_____ 7/7/17

PATIENT SIGNATURE (or Parent of Minor) Date:

EXAMPLE

* EXAMPLE *

CHIROFIT

PATIENT INTAKE FORM

Office Location_____

Informed Consent to Chiropractic/Medical Treatment/HIPPA/Assignment of Benefits

This form contains how your Patient Health Information (PHI) will be used in our office. By signing at the end of these policies, you agree to all stipulations.

Initial _____

1. The patient understands and agrees to allow CHIROFIT Chiropractic and Physical Therapy (CHIROFIT) and Arizona Medical & Injury (AZ Med) to use their PHI for the purpose of treatment, payment, health care operations and coordination of care.
2. The patient has the right to exam and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained on time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by CHIROFIT to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse care.

Authorization, Assignments of Benefits and Consent to Treat

To: CHIROFIT and AZ Med Doctors, hereafter refer to as OFFICE:

1. I authorize, assign and direct my insurance carrier, to pay directly to said OFFICE such sums as maybe due and owing the OFFICE, of services rendered me, now or hereafter, which are payable under my insurance contract, or contractual agreement.
2. Patient agrees, that in the event patient receives any checks, drafts or other payment subject to this agreement, patient agrees to act as fiduciary agent to the OFFICE. The OFFICE agrees to apply any proceeds to the patient's debt for services rendered.
3. I fully understand and agree insurance policies are an arrangement between the insurance carrier and myself. I will be responsible for expenses not paid by insurance. I understand and agree that either health insurance or automobile insurance may not pay all of the charges of the OFFICE for my treatment. I understand and agree to pay the customary charges of the OFFICE and agree that if my health insurance or automobile does not pay for my treatment in full, I will be responsible for the remaining balance. I understand and agree that I will be charged for missed appointments and it may be necessary for the OFFICE to record a lien on my case to ensure payment. I agree to pay the charges associated with filing of the lien.
4. I understand that if necessary the OFFICE may employ collection counsel and/or an attorney on my bill, I the patient will be responsible for any said collection and/or attorney fees.
5. I understand that if I do not cancel a massage appointment 24 hours in advance of the appointment I may be charged a $25.00 cancellation fee.
6. I agree the OFFICE has the right to call my home or place of employment regarding appointment and/or insurance issues.
7. I give permission to the office to send me birthday cards, holiday-related cards, thank you cards and gifts. Call me and/or leave me messages for me on an answering machine. Provide me information on treatment and other health related information. Allow staff and other patients to view my name on the sign in register. Treat me in a semi-open room where others may see me if passing by in the hall.
8. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, nutritional assessment and diagnosis x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or licensed doctors of chiropractic who know or in the future treat me while employed by, or are associated with or serving as back-up for the doctor of chiropractic, including those working at the clinic or office or any other office or clinic.
9. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, as in my best interest.
10. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about it, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) I seek treatment.
11. A photocopy of this form shall be valid as original.

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

_____ 7/7/17

Signature of Patient/Guardian if Patient Minor — Date