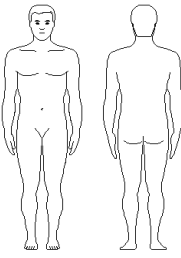


Chiropractic Progress Notes

Patient Name: _____			HA=Headache NC=No Change N/T=Numbness & Tingling		
Subjective:		Date: _____	Subjective:		Date: _____
Patient reports: <input type="checkbox"/> Pain <input type="checkbox"/> ↑ <input type="checkbox"/> ↓ NC <input type="checkbox"/> Spasm <input type="checkbox"/> ↑ <input type="checkbox"/> ↓ NC <input type="checkbox"/> ROM <input type="checkbox"/> ↑ <input type="checkbox"/> ↓ NC <input type="checkbox"/> N/T <input type="checkbox"/> ↑ <input type="checkbox"/> ↓ NC <input type="checkbox"/> Strength <input type="checkbox"/> ↑ <input type="checkbox"/> ↓ NC <input type="checkbox"/> HA <input type="checkbox"/> ↑ <input type="checkbox"/> ↓ NC <input type="checkbox"/> ADL'S <input type="checkbox"/> ↑ <input type="checkbox"/> ↓ NC				Patient reports: <input type="checkbox"/> Pain <input type="checkbox"/> ↑ <input type="checkbox"/> ↓ NC <input type="checkbox"/> Spasm <input type="checkbox"/> ↑ <input type="checkbox"/> ↓ NC <input type="checkbox"/> ROM <input type="checkbox"/> ↑ <input type="checkbox"/> ↓ NC <input type="checkbox"/> N/T <input type="checkbox"/> ↑ <input type="checkbox"/> ↓ NC <input type="checkbox"/> Strength <input type="checkbox"/> ↑ <input type="checkbox"/> ↓ NC <input type="checkbox"/> HA <input type="checkbox"/> ↑ <input type="checkbox"/> ↓ NC <input type="checkbox"/> ADL'S <input type="checkbox"/> ↑ <input type="checkbox"/> ↓ NC	
Severity: 0 1 2 3 4 5 6 7 8 9 10		Severity: 0 1 2 3 4 5 6 7 8 9 10		Severity: 0 1 2 3 4 5 6 7 8 9 10	
Type of pain: <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Dull/Aching/Throb <input type="checkbox"/> Sharp/Stabbing <input type="checkbox"/> Swelling <input type="checkbox"/> Burning <input type="checkbox"/> Stiffness		Frequency: <input type="checkbox"/> Certain movements <input type="checkbox"/> Occasional 0-25% <input type="checkbox"/> Intermittent 26-50% <input type="checkbox"/> Frequent 51-75% <input type="checkbox"/> Consistent 76-95% <input type="checkbox"/> Always 95-100%		Type of pain: <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Dull/Aching/Throb <input type="checkbox"/> Sharp/Stabbing <input type="checkbox"/> Swelling <input type="checkbox"/> Burning <input type="checkbox"/> Stiffness	
Objective: Comments		Objective: Comments		Objective: Comments	
<input type="checkbox"/> Spinal Dysfunction		<input type="checkbox"/> Spinal Dysfunction		<input type="checkbox"/> Spinal Dysfunction	
<input type="checkbox"/> Tenderness		<input type="checkbox"/> Tenderness		<input type="checkbox"/> Tenderness	
<input type="checkbox"/> Spasm/TP's		<input type="checkbox"/> Spasm/TP's		<input type="checkbox"/> Spasm/TP's	
<input type="checkbox"/> Strength		<input type="checkbox"/> Strength		<input type="checkbox"/> Strength	
<input type="checkbox"/> ROM		<input type="checkbox"/> ROM		<input type="checkbox"/> ROM	
<input type="checkbox"/> NC		<input type="checkbox"/> NC		<input type="checkbox"/> NC	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	
Assessment:		Assessment:		Assessment:	
<input type="checkbox"/> Progressing	<input type="checkbox"/> No change	<input type="checkbox"/> Progressing	<input type="checkbox"/> No change	<input type="checkbox"/> Progressing	<input type="checkbox"/> No change
<input type="checkbox"/> Regressed	<input type="checkbox"/> Exacerbation	<input type="checkbox"/> Regressed	<input type="checkbox"/> Exacerbation	<input type="checkbox"/> Regressed	<input type="checkbox"/> Exacerbation
<input type="checkbox"/> Resolved	<input type="checkbox"/> New Condition	<input type="checkbox"/> Resolved	<input type="checkbox"/> New Condition	<input type="checkbox"/> Resolved	<input type="checkbox"/> New Condition
Plan:		Plan:		Plan:	
<input type="checkbox"/> CMT	<input type="checkbox"/> Manual Therapy	<input type="checkbox"/> CMT	<input type="checkbox"/> Manual Therapy	<input type="checkbox"/> CMT	<input type="checkbox"/> Manual Therapy
<input type="checkbox"/> Modalities	<input type="checkbox"/> Instruction	<input type="checkbox"/> Modalities	<input type="checkbox"/> Instruction	<input type="checkbox"/> Modalities	<input type="checkbox"/> Instruction
Phase of Care:	<input type="checkbox"/> Discharge	Phase of Care:	<input type="checkbox"/> Discharge	Phase of Care:	<input type="checkbox"/> Discharge
<input type="checkbox"/> Relief	<input type="checkbox"/> Rehab	<input type="checkbox"/> Supportive	<input type="checkbox"/> Preventive	<input type="checkbox"/> Relief	<input type="checkbox"/> Rehab
<input type="checkbox"/> Supportive	<input type="checkbox"/> Preventive	<input type="checkbox"/> Supportive	<input type="checkbox"/> Preventive	<input type="checkbox"/> Supportive	<input type="checkbox"/> Preventive
Visit Freq.:	<input type="checkbox"/> 3x/wk <input type="checkbox"/> 2x/wk <input type="checkbox"/> 1x/wk	Visit Freq.:	<input type="checkbox"/> 3x/wk <input type="checkbox"/> 2x/wk <input type="checkbox"/> 1x/wk	Visit Freq.:	<input type="checkbox"/> 3x/wk <input type="checkbox"/> 2x/wk <input type="checkbox"/> 1x/wk
	<input type="checkbox"/> 1x/2wks <input type="checkbox"/> 1x/3wks <input type="checkbox"/> 1x/mth <input type="checkbox"/> PRN		<input type="checkbox"/> 1x/2wks <input type="checkbox"/> 1x/3wks <input type="checkbox"/> 1x/mth <input type="checkbox"/> PRN		<input type="checkbox"/> 1x/2wks <input type="checkbox"/> 1x/3wks <input type="checkbox"/> 1x/mth <input type="checkbox"/> PRN
Codes	Treatment	CPT	Codes	Treatment	CPT
<input type="checkbox"/> A0	Adjustment - 1 Region	98940	<input type="checkbox"/> A0	Adjustment - 1 Region	98940
<input type="checkbox"/> A1	Adjustment - 2/3	98941	<input type="checkbox"/> A1	Adjustment - 2/3	98941
<input type="checkbox"/> A2	Adjustment - 4/5	98942	<input type="checkbox"/> A2	Adjustment - 4/5	98942
<input type="checkbox"/> A3	Adjustment - Extr	98943	<input type="checkbox"/> A3	Adjustment - Extr	98943
<input type="checkbox"/> aPT	Therapeutic Exerc.	97110	<input type="checkbox"/> aPT	Therapeutic Exerc.	97110
<input type="checkbox"/> aNM	Neuromuscular Re-Ed.	97112	<input type="checkbox"/> aNM	Neuromuscular Re-Ed.	97112
<input type="checkbox"/> aMT	Manual Therapy	97140	<input type="checkbox"/> aMT	Manual Therapy	97140
<input type="checkbox"/> aIST	Traction Mechanical	97012	<input type="checkbox"/> aIST	Traction Mechanical	97012
<input type="checkbox"/> aES	Electric Stim.	97014	<input type="checkbox"/> aES	Electric Stim.	97014
<input type="checkbox"/> aMES	Manual Electric Stim.	97032	<input type="checkbox"/> aMES	Manual Electric Stim.	97032
<input type="checkbox"/> aUS	Ultrasound	97035	<input type="checkbox"/> aUS	Ultrasound	97035
<input type="checkbox"/> oNE	Office Visit New Exp.	99202	<input type="checkbox"/> oNE	Office Visit New Exp.	99202
<input type="checkbox"/> oN	Office Visit New Det.	99203	<input type="checkbox"/> oN	Office Visit New Det.	99203
<input type="checkbox"/> oEE	Office Visit Est. Exp.	99212	<input type="checkbox"/> oEE	Office Visit Est. Exp.	99212
<input type="checkbox"/> Other:			<input type="checkbox"/> Other:		
Notes:			Notes:		

Doctor's Initials: _____

Doctor's Initials: _____

Doctor's Initials: _____