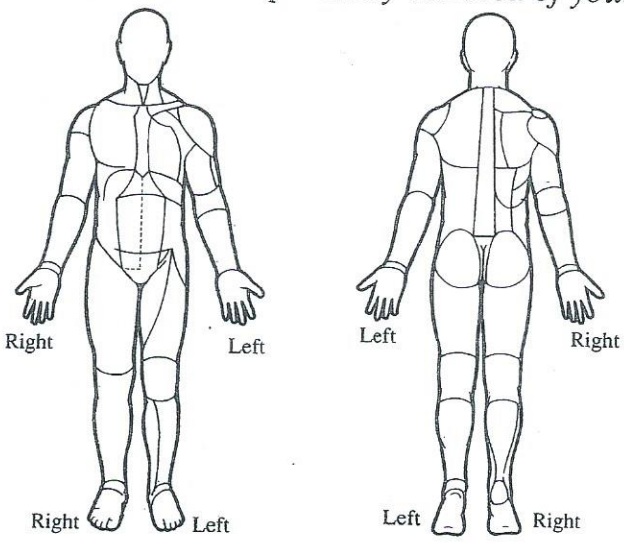
Patient's Daily Progress Report / Treatment Notes / Documentation Soap Notes

Patient # _____

Patient Name _____ Date _____ Visit # _____
(Please print) last first

PDPR *Please indicate precisely the area of your symptoms using these symbols to describe pain.*



[] Numbness
/ Stabbing
Burning
Circle Pain Area
* Tingling

Since your last visit ...

Any NEW conditions?	yes	no
New accident/injury?	yes	no
Have you seen another Dr.?	yes	no
Have you missed work?	yes	no
If so, are you still off?	yes	no
Last date worked _____		
Changes since last visit?	yes	no

_____

_____

_____

Name your condition below.	***Circle the severity with "0" being perfect and "10" severe***	***Compared to last visit***
1. _____	0 1 2 3 4 5 6 7 8 9 10	better same worse
2. _____	0 1 2 3 4 5 6 7 8 9 10	better same worse
3. _____	0 1 2 3 4 5 6 7 8 9 10	better same worse

Patient:

Patient's signature:

X _____

Notes:

MEDICARE PATIENT'S ONLY:

Medicare will pay only for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. Therefore, today's charges may not be paid by Medicare because of utilization parameters and you will be liable for the charges. I have been notified by my physician/supplier that he believes that, in my case, if Medicare denies payment, I agree to be personally and fully responsible for payment.

SUBJECTIVE

1. See notes
2. See PDPR
3. Visual Analog Pain Scale _____
4. Patient reports
   a. new injury
   b. re-injury
   c. exacerbation
   d. new symptom
5. See patient re-exam/progress form

OBJECTIVE

1. Spasm C T L
2. Trigger Points C T L
3. Tenderness C T L
4. Numbness, Swelling or Edema C T L
5. Short leg Left / Right
6. Short arm Left / Right
7. R.O.M. C T L
8. Bilateral Weight heavy on LT RT _____

PLAN

1. No change
2. Visit frequency _____ # of weeks

Daily 3x/week 2x/week 1x/week
2 weeks 3 weeks 4 weeks As needed
1 mo. 2 mos. 3 mos. 6 mos.

RE: a) non-response
b) adverse response
c) improvement

3. New condition
4. Treatment goals
   Relief Strength Stabilize
   Increase-ROM
   ▲ Function
   ▼ Inflamation

ASSESMENT

Condition Assessment:
1. Slower than expected
2. Progressing as expected
3. Faster than expected
4. Too soon to tell

Improvement Rating:
0. Resolved
1. Improving greatly
2. Improving
3. Improving slowly
4. Staying the same
5. Worse
6. Much worse

Patient Feelings:
0. Well
1. Much better
2. A little better
3. The same
4. Worse
5. Much worse

Progress Affected by:
1. Work
2. Obesity
3. Intermittent pain
4. Persistent pain
5. Complicating illness
6. Other symptoms
7. Non-compliance
8. Missing appointments
9. Exacerbation

Other _____

PROGNOSIS

• Excellent • Good • Fair • Poor
• Guarded • MMI/MCI-too soon to tell
• Expect return to normal • Expect residuals
• Unknown • Non-compliance, unknown

TENDERNESS

C1
C2
C3
C4
C5
C6
C7
T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12
L1
L2
L3
L4
L5
Head
Upper
Lower
Rib Cage
Abdomen

DOCTOR

___ OV	___ Adjustment, 1-2 regions
___ OV3	___ Adjustment, 3-4 regions
___ OVE	___ Adjustment, extremities
___ ROF	___ Report of Findings

ROF DIAGNOSTICS

___ DUSN	___ Diag. Ultrasound Cervical
___ DUSL	___ Diag. Ultrasound Lumbar
___ DUSE	___ Diag. Ultrasound Extremity
___ MST	___ Muscle Test Cer/Lum
___ ROM	___ Range of Motion Cer/Lum
___ EMG	___ E.M.G. Cerv/Thor/Lum
___ DUSI	___ SI
___ DUTR	___ TRAPS

Supplies and Supports

OTH	Orthotics
OTFT	Orthotics (fitting/training)
OF	Orthotics Follow Up
OM	Orthotic Mailing
SLB	Lumbar Support
CWP	Water Cervical Pillow
SLP	Lumbar Pillow
BIO	Biofreeze
TU	Tens Unit
TH	Thermophore
IP	Ice Pack
TB	Theraball
SCP	Tri Core Pillow
SHL	Heel Lift _____
IS	Industrial Support
	Other _____

PATIENT EXAMINATION – X-RAY
MEDICALLY NECESSARY SERVICES

DE	Detailed Exam
RE	Estab. Re-Exam
XLFS	FSAP
XCAP	Cerv AP
XCL	Cerv LAT
XCAPL	Cerv AP+L
XC4	View C-4
XCDS	C-Davis
XTAP	Thor AP
XTL	Thor LAT
XLAP	Lumb AP
XLL	Lumb LAT
XLAL	Lumb AP LAT
XSB	Sacral Base
_____	Other

	Units	Therapies/Modalities	Time	Area	Other
MR	____	Myofacial	_____min.	C T L	_____
ES	____	Interferential 120/1-15HZ	_____min.	C T L	_____
TX	____	Intersegmental TX	_____min.	C T L	_____
		(Flexion Distvaction)	_____min.	C T L	_____
		(Axial Decomp)	_____min.	C T L	_____
VD	____	Vasopneumatic	_____min.	C T L	_____
CT	____	CTD __MI __LT __RT	_____min.	C T L	_____
US	____	Ultrasound (con't/pulsed)	_____min.	C T L	1.0 w/cm²
PB	____	Paraffin Bath	_____min.	L/RT	_____
WP	____	Whirlpool	_____min.	C T L	_____
ADL	____	Self Home Care	_____min.	C T L	_____
NR	____	NMR (Stabilizing Bladder) (Limb Loading) (Wobble Board)	_____min.	C T L	_____
DA	____	DYN Activity (Back Builder)	_____min.	C T L	_____
DI	____	DiATHERNY			
TE	____	Therapeutic EX (Stretch Trainer) (Stationary Bike)	_____min.	C T L	_____
FCE	____	Funct. Capacity	_____min.	C T L	_____

Treatment Frequency _____ Next Visit M-T-W-Th-F-S-Su

Tx# _____ Credit $_____ Dr. Signature _____