Office Note

Patient Name: _____ Date: _____

	Subjective Complaints	Pain Intensity	Pain Frequency
	Headache	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
	Neck	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
	Shoulder	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
	Arm	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
	Hand	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
	Finger	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
	Elbow	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
	Wrist	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
	Upper Back	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
	Mid Back	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
	Low Back	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
	Hip	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
	Buttock	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
	Leg	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
	Knee	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
	Chest	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
		0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
		0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
		0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Objective Findings:
☐**Problem** ☐ ☐**None**

Cervicothoracic Range of Motion
☐ Restricted: Not within normal limits
☐ Restricted: With some improvement
☐ Within normal limits

Lumbosacral Range of Motion.
☐ Restricted: Not within normal limits
☐ Restricted: With some improvement
☐ Within normal limits

Restricted Range of Motion
☐ Shoulder ☐Elbow ☐ Wrist ☐ Knee
☐ Ankle ☐ _____ ☐ _____

Muscle Hypertonicity & Tenderness
☐ Cervical ☐ Thoracic ☐ Lumbar
☐ Lumbosacral ☐ SI ☐ Shoulder
☐ _____ ☐ _____ ☐ _____

Subluxation: C/S T/S L/S S RIL LIL
Short Leg: ☐Left ☐Right
Palpable Swelling / Edema:
☐ _____
☐ _____

Other:
☐ _____
☐ _____
☐ _____

Assessment

☐ Guarded
☐ Some Improvement
☐ Satisfactory Progress
☐ Stabilizing
☐ No Change
☐ Exacerbation
☐ Aggravated
☐ Regressed
☐ New Injury
☐ Complications
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

Treatment Rendered:

☐**98941** ☐**98940**	**Activator Arthrostim**	C1 C2 C3 C4 C5 C6 C7 T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12
☐**98943**	**Drop Table Manual**	L1 L2 L3 L4 L5 Sacrum RIL LIL
☐ **G0283**	**EMS:**	C/S - T/S - L/S - LS/S - Shoulder Time: Minutes
☐ **97035**	**Ultrasound:**	C/S - T/S - L/S - LS/S - Shoulder Time: Minutes
☐ **97012**	**Traction:**	C/S - T/S - L/S Force LBS Intermittent - Static Time: Minutes
☐ **97124-59**	**Massage:** by: _____	to the C/S-T/S-L/S-LS/S-Shoulder for Time: Minutes
☐ **97140-59**	**Trigger Point Therapy-Myofascial Release:** performed by _____	to the C/S - T/S - L/S - LS/S – Shoulder for Time: Minutes
☐ **97110**	**Therapeutic Exercise:**	Time Minutes
☐ **97039**	**Hydrotherapy:**	C/S - T/S - L/S - LS/S - Shoulder for Time: Minutes
☐ **97039**	**Roller Traction / Massage:**	C/S - T/S - L/S - LS/S for Time: Minutes
☐ **97150**	**Exercise:**	Time Minutes

Recommendations: ☐**Continue Treatment** ☐**Orthopedic Consultation** ☐**Neurologic Consultation** ☐**Consult PCP** ☐ _____
☐**MRI of the** _____ ☐☐**EMG & NCV of the** _____ ☐_____
☐_____

Patient & Doctor Comments: _____

_____

_____

_____

_____

I certify and understand that I have received the above noted therapies and have suffered no ill effects:_____