

# Mobility Physical Therapy

19232 Seaclyff Drive  
Edmonds, WA 98002-  
Phone (425) 555-7890 Fax (425) 555-3454

# Chiropractic

## CHIROPRACTIC EVALUATION

**Patient:** Roe, Stephen

**Date** 07-Apr-09

**Dx #1** 847.0 - Sprain (cervical)  
#2 726.91 - Bone spur NOS

**Date of Birth** 11-Nov-46 **Age** 62  
**Gender** Male  
**Claim** 6075421  
**Account** 98179  
**Occupation** Press Operator  
**Employer** Rockville Industries  
**Employment** Off Work

**Date of Onset** 02-Apr-09 **Start of Care** 07-Apr-09

**Physician**

**Insurance** Standard Insurance

### History

**CHIEF COMPLAINT**  Heachache  Cervical pain  Thoracic pain  Lumbar pain  Paraesthesia  MuscleSpasm  
 Dizziness  Visual change  Radicular pain  Joint stiffnes

#### Comments

Neck pain and occipital headaches for past two months

#### MECHANISM OF INJURY

AA - rearended - was driver

#### PREVIOUS HISTORY OF TREATMENT FOR COMPLAINT(S)

ER visit - instructed in home cold packs 2 - 3x/day as needed

#### PREVIOUS SURGERIES

none reported

**MEDICATIONS** anti-inflammatory and OTC pain medications

#### MED. HISTORY

### Examination

#### VASCULAR RISKS

	Date		Relationship	Age
Have you ever had a stroke?	<input type="checkbox"/>	Has anyone in your family had a stroke?	<input type="checkbox"/>	
Have you ever had a heart attack?	<input type="checkbox"/>	Has anyone in your familiy had a heart attack?	<input checked="" type="checkbox"/> Father	54
Do you have a vascular disease?	<input checked="" type="checkbox"/>	Does anyone in your familiy have a vascular disease?	<input checked="" type="checkbox"/> Mother	50
Do you have high blood pressure?	<input checked="" type="checkbox"/>	Does anyone in your familiy have high blood pressure?	<input checked="" type="checkbox"/> Father	54
Do you smoke?	<input checked="" type="checkbox"/>	If No, when did you quit?		
Do you take birth control pills?	<input type="checkbox"/>			

**Blood pressure** 154/110

**Pulse** 80

**Temperature** 98.7 F

**George's test** negative

**Deklyn's test** positive

**Barre Leiow** negative

#### SOFT TISSUES

<input checked="" type="checkbox"/> <b>Hypertonicity</b>	<input checked="" type="checkbox"/> <b>Weakness</b>	<input checked="" type="checkbox"/> <b>Assymetry</b>
<b>L R</b>		elevated L shld
<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> Cervical		
<input type="checkbox"/> <input type="checkbox"/> Thoracic		
<input checked="" type="checkbox"/> <input type="checkbox"/> Lumbar		
<input type="checkbox"/> <input type="checkbox"/>		

#### Comment

#### OBSERVATIONS

Guarded posture, patient reluctant to try mobility exercises - concerned movement will increase pain intensity

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**MUSCLE TESTING**

	Left	Right		Left	Right		Left	Right
Deltoid C5	4-	4+	Finger flx. C8	4+	5	Foot eversion S1		
Wrist ext. C6	4-	4	Interossei T1	5	5	Foot PF S1		
Wrist flx. C7	4+	4	DF and inversion L4			Heel walk L4		
Triceps C7	3-	3+	1st toe ext. L5			Toe walk L5		

ROM	Body Part	Cervical	Body Part	Body Part
	AROM	Degrees	Degrees	Degrees
FLX		24		
EXT		15		
LT. LAT BEND		21		
RT. LAT BEND		14		
LT. ROT		45		
RT. ROT		72		

**Comment**

**POSTURE**

	L	R		L	R		L	R
Elevated pelvis on	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Head rotation to	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Elevated shoulder on	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Pelvis rotation to	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Head protrusion	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Shoulder rotation on	<input type="checkbox"/>	<input type="checkbox"/>
Post pelvic tilt	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Head tilt to	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Ant pelvic tilt	<input type="checkbox"/>	<input checked="" type="checkbox"/>						

**Comment**

**GAIT**

	L	R		L	R		L	R
Heel to toe	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Shortened stride	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Excessive pronation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Heel strike	<input type="checkbox"/>	<input type="checkbox"/>	Decreased WB	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Walk on toes	<input type="checkbox"/>	<input type="checkbox"/>	Excessive hip flx.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			

**Comment**

**SENSORY** (Check indicates diminished sensory response.)

	L	R		L	R		L	R
C5	<input type="checkbox"/>	<input type="checkbox"/>	T1	<input type="checkbox"/>	<input type="checkbox"/>	L4	<input type="checkbox"/>	<input type="checkbox"/>
C6	<input checked="" type="checkbox"/>	<input type="checkbox"/>	L1	<input type="checkbox"/>	<input type="checkbox"/>	L5	<input type="checkbox"/>	<input type="checkbox"/>
C7	<input checked="" type="checkbox"/>	<input type="checkbox"/>	L2	<input type="checkbox"/>	<input type="checkbox"/>	S1	<input type="checkbox"/>	<input type="checkbox"/>
C8	<input checked="" type="checkbox"/>	<input type="checkbox"/>	L3	<input type="checkbox"/>	<input type="checkbox"/>			

**Comment**

**REFLEXES**

	Left	Right		Left	Right
Biceps	2+	3	Patellar		
Triceps	1+	3	Achilles		
Brachioradialis	2+	3			

**PAIN** **Current** 5 **Frequency** intermittent  
**Best** 3 **Descriptive** radiating  
**Worst** 7  
**(scale of 0 to 10)**

**Comment**

Location	L	R	L	R	L	R
<input checked="" type="checkbox"/> <input type="checkbox"/> neck	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> upper back	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> <input type="checkbox"/> shoulder	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> mid back	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> <input type="checkbox"/> arm	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> low back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>

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### PROVOCATIVE TESTS

(Check indicates positive sign)

- |   |  |   |   |   |
|---|--|---|---|---|
| <input checked="" type="checkbox"/> Spurling's          | <input type="checkbox"/> Swallowing              | <input type="checkbox"/> DeJérine's             | <input type="checkbox"/> Goldthwait's test            | <input checked="" type="checkbox"/> Trendelenberg |
| <input type="checkbox"/> Jackson's comp.                | <input type="checkbox"/> Soto-Hall test          | <input type="checkbox"/> Milgram's test         | <input type="checkbox"/> Yoeman's                     | <input checked="" type="checkbox"/> Rhomberg      |
| <input checked="" type="checkbox"/> Maximal forminal    | <input checked="" type="checkbox"/> Adson's test | <input type="checkbox"/> Straight leg raise     | <input checked="" type="checkbox"/> Nachlas-Ely       | <input type="checkbox"/> Babinski                 |
| <input checked="" type="checkbox"/> Shoulder depression | <input type="checkbox"/> Bakody sign             | <input type="checkbox"/> Minor's sign           | <input type="checkbox"/> Braggard's                   | <input type="checkbox"/>                          |
| <input checked="" type="checkbox"/> Cerv. Distraction   | <input type="checkbox"/> Valsalvas maneuver      | <input checked="" type="checkbox"/> Kemp's test | <input checked="" type="checkbox"/> Spinal percussion | <input type="checkbox"/>                          |

### Comments

### JOINT SUBLUXATIONS / FIXATIONS

Cervical	L	R	Thoracic	L	R	Thoracic	L	R	Lumbar	L	R	Extremities	L	R
C0	2+		T1			T9			L1			Shoulder		
C1			T2			T10			L2			Elbow		
C2			T3			T11			L3			Wrist		
C3			T4			T12			L4			Hip		
C4			T5						L5			Knee		
C5			T6						Sacrum			Ankle		
C6			T7						Ilium					
C7			T8						Coccyx					

### Comments

### STUDIES

#### Lab

no studies requested at this time

#### X-ray

1+ spur at C5-C6 (R lateral)

### Assessment

**Dx** 847.0 Sprain (cervical)  
726.91 Bone spur NOS

### SHORT TERM GOALS

Reduce neck pain 2 - 4 weeks  
Diminish cervical spasm 1 - 2 weeks  
Regain left cervical rotation 3 - 4 weeks

### LONG TERM GOALS

Reduce left arm pain 4 - 5 weeks  
Decrease headaches 3 - 4 weeks  
Regain functional cervical mobility 4 - 6 weeks

### Plan of Care

**ESTIMATED # OF MANIPULATIONS REQUIRED TO TREAT SUBLUXATION** 6

### TREATMENT

#### Chiropractic Adjustments

- CMT 1 - 2
- CMT 3 - 4
- Extremity

#### ----- Therapeutic Modalities -----

- Ultrasound
- Massage therapy
- Location cervical spine
- Myofascial release
- Intensity graduated
- Kinetic activity

#### Comment

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### Home Instruction

#### Exercise Program

- Stretching
- Strengthening
- Proprioceptive training
- Gait training
- 

#### Modalities

- Ice
- Heat
- Traction
- 

#### Ergonomics

- Adaptations at work
- Positioning
- Sleep posture
- Modify ADLs
- 

### Recommendations

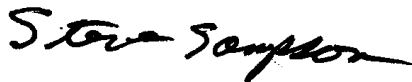
- Joint mobilization
- Job site review
- 
- Referral for diagnostic imagin
- Referral for consult
- 

**REHAB POTENTIAL** Good

**Time Start** 9:13 AM **Stop** 9:56 AM

### Today's Treatment Record

<u>Code</u>	<u>Description</u>	<u>Minutes</u>	<u>Units</u>	<u>Total</u>
72040	Cervical AP/LAT AP OPEN	0	1	0
98940	CMT 1-2 Regions	0	2	0
98941	CMT 3-4 Regions	0	1	0
<b>Total Treatment Time</b>				0



**Steve Sampson, DC**  
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