

Chapter 1- Introduction

7
Forms

Health Promotion and Wellness Checklist

NEW YORK CHIROPRACTIC COLLEGE

The following list is intended to be a guide for the attending chiropractor. Individual health history and current presentation may necessitate variations in the course of care. Certain items may not be necessary or appropriate to discuss at this time.

The following items were addressed with _____ (Name) on _____ (Date).

Checklist	Suggested Intervention Resource	
Posture	http://www.straightenupamerica.org	770-426-2709
Exercise	http://www.presidentschallenge.org	800-258-8146
Weight/Obesity	http://www.apha.org/ppp/obesity_toolkit	202-777-2742
	http://www.nysphysicalactivity.org	716-851-4052
Nutrition	http://www.fns.usda.gov/eatsmartplayhard/	
	http://www.5aday.gov	(NY only) 800-522-5006
Workplace Safety	http://www.cdc.gov/niosh/topics/safety.html	800-356-4674
Injury Risk	http://www.cdc.gov/ncipc/duip/fallsmaterial.htm	800-232-4636
Tobacco Usage	http://www.nysmokefree.com	866-697-8487
Arthritis	http://www.arthritis.org	404-872-7100
Diabetes	http://www.diabetes.org/for-health-professionals-and-scientists/CVD.jsp	800-342-2383
Heart disease	http://www.americanheart.org	800-242-8721
Risk of Stroke	http://www.stroke.org/	800-787-6537
	http://www.strokeassociation.org	
Osteoporosis	http://www.nof.org/prevention/index.htm	202-223-2226
	http://www.nof.org/osteoporosis/index.htm	
Risk of Cancer	http://www.cancer.gov/	800-422-6237
	http://www.cancer.org/docroot/ped/ped_0.asp	
Other	_____	
	_____	

Additional recommendations:

Health Professional Referral _____

Health Promotion Program Referral _____

_____

Patient Instructions: _____

_____

_____

Clinician: _____ Date: _____

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COMPREHENSIVE EXAMINATION

Dr._____ **Date of Exam** __/__/____ **Date of Injury/Illness**_____

Pt Name _____ **D.O.B.**__/__/____ ☐**Male** ☐**Female** ☐**New Pt** ☐**Est Pt**

Chief Complaint History: _____

Vitals
Resp _____ cpm Pulse _____bpm
Temp_____ °F
Blood Pressure:_____ mmHg

Height: _____in.
Weight: _____lbs

Hand Dominance:
☐Right ☐Left

Gait: ☐Normal ☐Abnormal Notes:_____

Ambulation: ☐Normal ☐Impaired ☐Difficult
☐ Assisted ☐Cane ☐Pain ☐Wheelchair
Notes:_____

Vascular Screening B=Bruits or Grading = X/4	Left	Right
Orbital		
Carotid		
Subclavian		
Radial		
Ulnar		
Abdominal		
Femoral		
Popliteal		
Post. Tibial		
Dorsalis Pedis		

Body Type: ☐Ectomorph ☐Endomorph
☐Mesomorph ☐Obese ☐Gracile Habitus

E.E.N.T. / Lymph Node / Thyroid / Cardiopulmonary / Abdominal: _____

Additional Observations: _____

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PT NAME Pg 2

Cranial Nerves ☐Normal _____

_____

_____

Range of Motion A=Active P=Passive B=Both N=Normal *Taken from AMA Guides to the Eval. of Perm. Impair 5th Ed. 2001

Cervical			☐WNL
Motion	Act.	Pas.	Pain
Flex. (50°)*			
Ext. (60°)*			
RLF (45°)*			
LLF (45°)*			
R. Rot (80°)*			
L. Rot (80°)*			

Thoracic		☐WNL
Motion	Act.	Pain
Flex. (50°)*		
Ext. (25°)		
RLF (20°)		
LLF (20°)		
R. Rot (30°)*		
L. Rot (30°)*		

Lumbar		☐WNL
Motion	Act.	Pain
Flex. (60°)*		
Ext. (25°)*		
RLF (25°)*		
LLF (25°)*		
R. Rot (35°)		
L. Rot (35°)		

Notes and/or Extremity R.O.M.: _____

_____

_____

_____

_____

Sensory Evaluation (Pain, Touch, position, and/or vibration)		
	Left	Right
UE		
LE		
Other		

Reflexes	Left	Right
Biceps		
Brachioradialis		
Triceps		
Patellar		
Achilles		
MedialHam.		
Abdominal		
Plantar		
Hoffman's Tromner's		
Meningeal Sign		

Motor Evaluation	Strength/Tone Left	Right
Biceps C5 C6 Musculocutaneous N.		
Deltoids C5 C6 Axillary N.		
Wrist Extensors C6 C7 C8 Radial N.		
Wrist Flexors C6 C7 C8 Median N. Ulnar N		
Triceps C6 C7 C8 Radial N.		
Finger Flexors C8 C1 Median N Ulnar N		
Finger Abductors C8 T1 Ulnar N.		
Finger Extensors C6 C7 C8 Radial N		
Hip Flexors L1 L2 L3 Femoral and Spinal N.		
Hip Extensors L5 S1 S2 Inf Glut N		
Hip Adductors L2 L3 L4 Obturator N		
Knee Flexor L4 L5 S1 Sciatic N.		
Knee Extensors L2 L3 L4 Femoral N.		
Extensor Hallicus Longus L4 L5 S1 Dp Peron.		
Ankle Plantarflex (Toe Walk) L5 S1 S2 Tibial N.		
Ankle Dorsiflex (Heal Walk) L4 L5 Dp Peron N		
Ankle Dorsiflex w/Invension L4 Dp Peron N		
Ankle Plantarflex w/Eversion S1 Sup. Peron N		

Muscle Bulk	Left	Right
Arm (cm)		
Forearm (cm)		
Thigh (cm)		
Leg (cm)		
Other		

Movement / Coordination	Left	Right
Romberg's Position		
Finger to Nose		
Heel to Shin		

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PT NAME Pg 3

Orthopedic & Neurological Evaluation

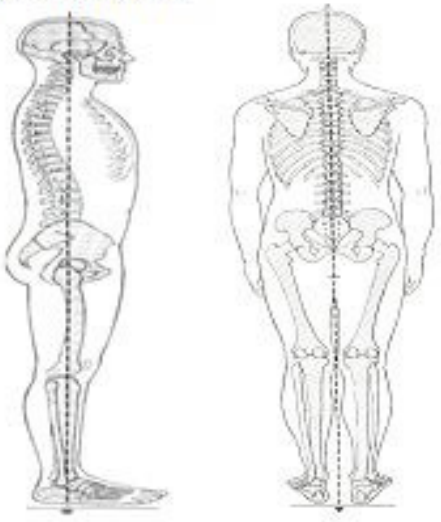
Test	Left	Right
Valsalva's		
Minor's Sign		
Cervical Compression		
Jackson's Lat. Compr.		
Foraminal Compression		
Cervical Distraction		
L'Hermitte's		
Soto-Hall Sign		
O'Donoghue's Man.		
Shoulder Depression		
Schepelmann's Sign		
Trendelenburg's Test		
Bechterew's		
Kemp's		
Adam's/Belt		
S.L.R.		
Braggard's		
Hyndman's Sign		
Lewin's Supine		
Ely's Test		
Patrick's/FABERE		
Yeoman's		
Gaenslen's Test		

Notes:

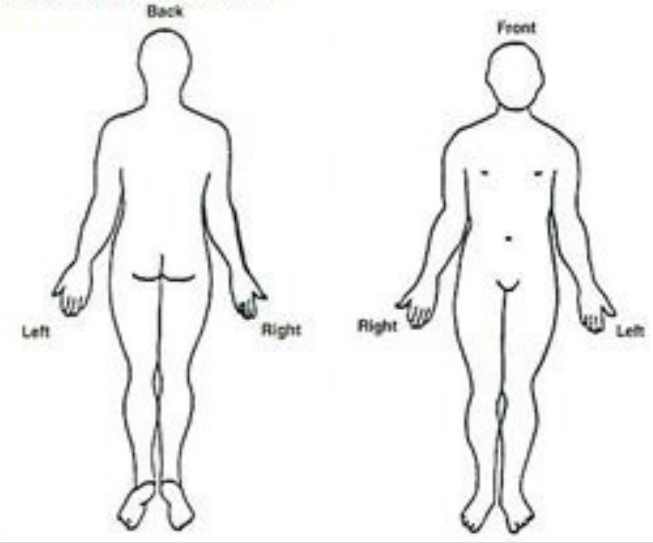
Soft Tissue Evaluation Key

H = Hypertonicity (Spasm) T = Tenderness
E = Edema Trp = Triggerpoints B = Tight band

Postural Analysis



Soft Tissue Evaluation



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PT NAME Pg 4

Spinal Evaluation

Left	Level	Right
	C0-C1	
	C1-C2	
	C2-C3	
	C3-C4	
	C4-C5	
	C5-C6	
	C6-C7	
	C7-T1	
	T1-T2	
	T2-T3	
	T3-T4	
	T4-T5	
	T5-T6	
	T6-T7	
	T7-T8	
	T8-T9	
	T9-T10	
	T10-T11	
	T11-T12	
	T12-L1	
	L1-L2	
	L2-L3	
	L3-L4	
	L4-L5	
	L5-S1	
	SI	
	Sac-Coc	

Notate: Joint Dysfunction, Tenderness*, Abnormal Tension*, and inflammation (*mild, mod, severe)

Additional Notes:_____

Clinical Impression:_____

Recommendations for additional testing:

Diagnosis: _____

Management Plan(tx frequency, active and passive care, restrictions, diet recs, referrals) :

Disability: _____

Prognosis: _____

Doctor's Signature Date

Intern's Signature Date

PROGRESS NOTE

PATIENT NAME: _____ **Date:** / /

Visit # Authorization good through / /	Clinician	CMT	Intern
☐ Routine Visit ☐ Re-Evaluation		CO - C1	
S		C1 - C2	
		C2 - C3	
		C3 - C4	
		C4 - C5	
O		C5 - C6	
		C6 - C7	
		C7 - T1	
		T1 - T2	
		T2 - T3	
		T3 - T4	
		T4 - T5	
		T5 - T6	
		T6 - T7	
		T7 - T8	
		T8 - T9	
		T9 - T10	
		T10 - T11	
		T11 - T12	
		T12- L1	
		L1 - L2	
		L2 - L3	
A Unchanged Improving as expected Resolved Re-Occurrence		L3 - L4	
M.T.B. (max. therapeutic benefit) Regressed Exacerbation		L4 - L5	
Diagnosis:		L5 - S1	
		SAC-COC	

P **Clinician:** MSTM Hot Pack Cryotherapy Ultrasound- pulsed/continuous _____ w/cm2
Manual ElectroStim Phototherapy
Other Modalities:
Compliance:
Exercises:
FOLLOW UP:
MISC: Ordering Requesting Referred to:

Intern: MSTM Hot Pack Cryotherapy Ultrasound- pulsed/continuous _____ w/cm2
Manual ElectroStim Phototherapy
Other Modalities:

_____ _____
Clinician Signature Intern Signature