Whom may we thank for referring you to this office → ______________________________________?

MERRIMON FAMILY CHIROPRACTIC

Today's Date: __________________ HRN: _____________________

Name: ____ Birth Date: _____-_____-_____ Age: _______ ☐ Male ☐ Female

Address: ____ City: ________________________________ State: _____ Zip: ____________

E-mail Address: ___________________________________ Home Phone: _______________ Mobile Phone:_________________

Marital Status: ❑ Single ❑ Married Do you have Insurance: ❑ Yes ❑ No Work Phone: _____________________________

Social Security #: __________________________________

Employer: _______________________________________ Occupation: ____

Spouse's / Partner Name ____Spouse's Employer __________________________________

Children and Ages: ________________________________ Hobbies: ____

Name & Number of Emergency Contact: _____________________ __________________Relationship: __________________________

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office:

Primarily: __________________________ Secondarily: __________________________ Third: _____________________________

Fourth: ______________________

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? ____________________ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

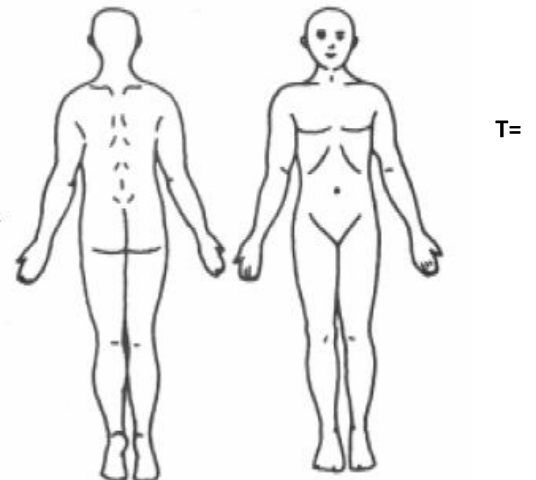
How did the injury happen?____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes If yes, when: ______ by whom? ________________________________

How long were you under care: ____________ What were the results? ____

Name of Previous Chiropractor: _______________________________ ☐ **N/A**

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = Aching **N** = **N**umbness **S** = **S**harp/ **S**tabbing **T**= **T**ingling



What relieves your symptoms? ____

What makes them feel worse? ____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? _________ _ When was the last episode? _______________________ How did the injury happen?_____________

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: ____________________________________, and who provided it: ___________________________ **How long ago? _______**What were the results. ☐ Favorable ☐ Unfavorable→ please explain. ____ _______________________________________

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

____

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
HOSPITALIZATIONS →			
SURGERIES →			
DISEASES →			

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)
Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know
2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: ____________________________

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never ❑Past
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never ❑Past
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never ❑Past
4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following, See pg 3- Activities of Life

I hereby authorize payment to be made directly to Merrimon Chiropractic], for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Merrimon Chiropractic for any and all services I receive at this office.

____ ______ - ______ - ______
Patient or Authorized Person's Signature **Date Completed**

____ _______ - _______ - ______
Doctor's Signature **Date Form Reviewed**

Patient's Name: ______________________________ HR#: __________________ ___/___/___ JDD,DC 5/20

Activities of Daily Living/ Symptoms

Patient Name: ___________________________________ File#____________
Date: ______________________

Daily Activities: Effects of Current conditions On Performance
Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Sleeping	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Bending	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Exercise (Sports/Dancing...)	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Physical Endurance-daily	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Mental Endurance-daily	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Concentration	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Stress	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Hobbies / Recreation	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Optimism	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Professional Relationships	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Personal Relationships	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Overall Satisfaction w/ Health	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Overall Satisfaction w/ Life	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform

Patient Name: ________________________________ File#___________
Date: ____________________

Please mark P for in the **Past, C** for **Currently** have and **N** for **Never**

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)
___ Broken Bones		___ Dislocations	___ Heart Attack	___ Tumors
___ Arthritis		___ Diabetes	___ Cancer	

List Prescription & Non-Prescription drugs you take:

Drug	How Often / DOSE	How Long
Example: Tramadol	Once a day / 200mg	7 years
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

Aside from your symptoms, do you have any other health concerns/goals?

____

____

____

____

Informed Consent / Privacy

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Merrimon Family Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized person's Signature Date

I have received a copy of Merrimon Family Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at an time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

____ ______________ ____________

Patient's Name DOB HR#

____ ______________

Patient signature Date

____ ______________

Witness Date

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized person's Signature Date

Merrimon Family Chiropractic Clinical Examination Findings

Patient's Name: ______________________________________ **DOB:** _______________ _______________ **Date:** ________________

1. Patient is alert and oriented to time, place, & person: YES NO

2. Mood and affect: Depression Anxiety Agitation Non-contributory

3. Posture

FHP	+	-
Head Tilt	L	R
Head Rot	L	R
↑Shoulder	L	R
Nodes/B.CA	Y	N

BP

Pulse

Height

Weight

4. Range of Motion

Cervical ROM					
Flex 50°	°	L Lat Flex 45°	°	L Rot 80°	°
Ext 60°	°	R Lat Flex 45°	°	R Rot 80°	°
Thoracic ROM					
Flex50°	°	L Rot 30°	°	R Rot 30°	°
Shoulder ROM					
Flex 180°	°	Int Rot 75°	°	Abd 150°	°
Ext 60°	°	Ext Rot 90°	°		
Lumbar ROM					
Flex 90°	°	L Lat Flex 30°	°		°
Ext 30°	°	R Lat Flex 30°	°		°
Knee ROM					
Flex 140°	°	Ext 10°	°		°
Hip ROM					
Flex 125°	°	Int Rot 40°	°	Abd 145°	°
Ext 30°	°	Ext Rot 60°	°	Add 25°	°

5. Palpation

Area	L/R	Pain	Spasm
C1			
C2			
C3			
C4			
C5			
C6			
C7			
T1			
T2			
T3			
T4			
T5			
T6			
T7			
T8			
T9			
T10			
T11			
T12			
L1			
L2			
L3			
L4			
L5			
LSI			
RSI			
Sac			

6. Orthopedics

	Orthopedics	Findings			
	Distraction	+	-	L	R
	Max Comp	+	-	L	R
	O'Donahue's	+	-	L	R
	Soto Hall	+	-	L	R
	Shoulder Dep	+	-	L	R
	Valsalva's	+	-	L	R
	Spinal Perc	+	-	L	R
	Finger/Nose	+	-	L	R
	Adson's	+	-	L	R
	Schepelmann	+	-	L	R
	Bowstring's	+	-	L	R
	Codman's	+	-	L	R
	Dawbarn's	+	-	L	R
	Dugas	+	-	L	R
	Impengent	+	-	L	R
	Gait	+	-	L	R
	SLR	+	-	L	R
	Braggard's	+	-	L	R
	Faber-Patrick	+	-	L	R
	Kemp's	+	-	L	R
	Yeoman's	+	-	L	R
	Ely's	+	-	L	R
	Toe Walk	+	-	L	R
	Sacral Apex	+	-	L	R
	Erichsen's	+	-	L	R
	Abd Str.	+	-	L	R
	Add Str.	+	-	L	R
	Apprehension	+	-	L	R
	Drawer Sign	+	-	L	R

7. Muscle Testing

Muscle	R Strength	L Strength
Biceps	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Brachio	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Wrist Ext.	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Triceps	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Finger Ext	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Fing Ab/Ad	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Grip	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Hip Flex	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Hip Ab	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Hip Ad	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Hip Ext	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Knee Flex	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Knee Ext	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Ank D Flex	0 1 2 3 4 **5**	0 1 2 3 4 **5**
Ank P Flex	0 1 2 3 4 **5**	0 1 2 3 4 **5**

8. Dermatomes

Level	↑	↓	Absent
C5			
C6			
C7			
T1			
L3			
L4			
L5			
S1			

L = Left R = Right All Tests

9. Reflexes

Reflex	R Grade	L Grade
Biceps	0 1 **2** 3 4	0 1 **2** 3 4
Triceps	0 1 **2** 3 4	0 1 **2** 3 4
Brachio	0 1 **2** 3 4	0 1 **2** 3 4
Patellar	0 1 **2** 3 4	0 1 **2** 3 4
Achilles	0 1 **2** 3 4	0 1 **2** 3 4

All Tests WNL (+2)

10. Asymmetry/Misalignment/Subluxations:

11. Diagnosis

1
2
3
4
5

Additional Notes:

Doctor/Examiner's Signature:____ **Date:** ________________________

Chiropractic Treatment Plan

Date: ___/___/___

TREATMENT PLAN recommendations for: ____ **HR#:**____________
(Patient's name)

CLINICAL INDICATION: *Observations, signs, and symptoms, point to the need for further diagnostics* in order to **initially**:

- ❑ **Rule out the presence of a** suspected disease/disorder
- ❑ **Confirm the** true nature and extent of the presenting problem
- X **Identify** exact location of **subluxations**
- ❑ **To monitor** pathology: ____
- ❑ **Subsequent** *studies will be obtained to measure segmental stability, movement, and motor unit integrity.*

ORDERS/ RECOMMENDATIONS FOR DIAGNOSTICS

DATES:	CERVICAL	THORACIC	LUMBAR	SACRUM	PELVIS	UPPER	LOWER
___/___/___	A-P LAT	A-P LAT	A-P LAT	A-P LAT	A-P LAT	____________	____________
___/___/___	A-P LAT	A-P LAT	A-P LAT	A-P LAT	A-P LAT	____________	____________
___/___/___	A-P LAT	A-P LAT	A-P LAT	A-P LAT	A-P LAT	____________	____________

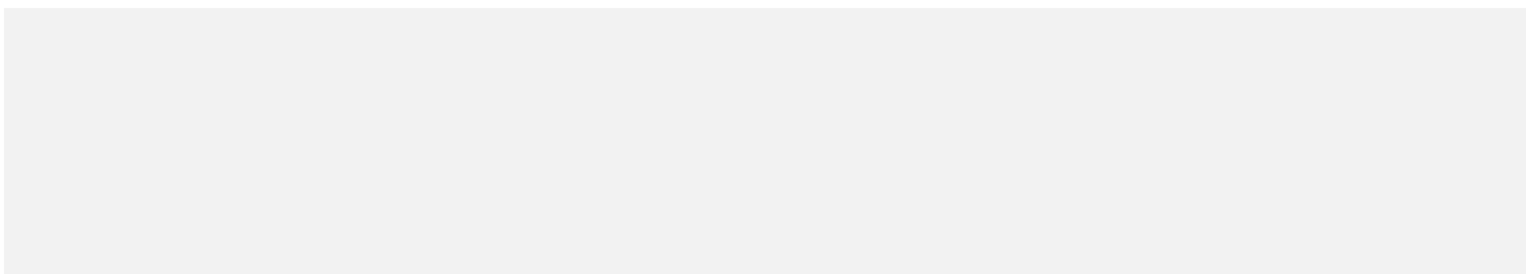
DIAGNOSTIC STATEMENT establishes 'NECESSITY'

Primary Condition	Associated Finding	Complicating Factor	Neurogenic Effect
1)	2)	3)	4)
1)	2)	3)	4)
1)	2)	3)	4)

GOALS AND OBJECTIVES:
The above condition(s) now confirmed as to certainty make it **'clinically necessary'** to approach the care and management of this patient using chiropractic spinal adjustments, as well as physical therapy procedures to achieve **short and long term goals. Care objectives initially focus on** decreasing pain, muscle spasms, swelling, and inflammation. Procedures are further aimed at increasing blood flow to bring nutrients to injured areas, which will facilitate healing so that muscle strength is restored, as well as pain free range of motion. This is anticipated to result in restoring full function, which will enable the patient to once again resume routine activities of daily life and in particular________________________________

DURATION OF CARE:
❑A-Based on the history of natural recovery from conditions such as these, the patient is expected to respond favorably to chiropractic treatment within two to four weeks and continue to improve over the next four to eight weeks. A reevaluation will be targeted for approximately 8 weeks from the initiation of care to determine if the current plan is working and measure the patient's progress. Barring any unforeseen complications, exacerbations, or new injuries, unless the patient responds at a rate greater or less than anticipated, a ***'follow-up'* examination** to evaluate the patients overall health status will occur in approximately 12 weeks, at which time a determination will be made as to the readiness of the patient to transcend therapeutic care, and begin their next phase of care.

❑B-Based on the history of natural recovery from conditions such as these, the patient is expected to respond favorably to chiropractic treatment within two to four weeks and continue to improve over the next four to eight weeks. A reevaluation will be targeted for approximately 4 weeks from the initiation of care to determine if the current plan is working and measure the patient's progress. Barring any unforeseen complications, exacerbations, or new injuries, unless the patient responds at a rate greater or less than anticipated, a ***'follow-up'* examination** to evaluate the patients overall health status will occur in approximately 8 weeks, at which time a determination will be made as to the readiness of the patient to transcend therapeutic care, and begin their next phase of care



RECOMMENDATIONS FOR TREATMENT TYPES and RATIONALE:

CHIROPRACTIC SPINAL ADJUSTMENTS will be performed to include routine "*interactive assessments*" at each encounter. The adjustments will reduce the subluxations that have resulted from a loss in the juxtaposition of the spinal motor units, and to minimize any further alteration in tissue by caused these mal- unions, which are responsible for manifesting symptoms such as pain, swelling, which effectively caused a loss in range of motion. The Chiropractic adjustment will restore proper alignment thus reducing the opportunity for tissue alteration, so that the body retains the mobility necessary to function pain free, at optimal capacity. Examination revealed the presence of subluxations and specific spinal adjustments will be made to specific segments within the following regions:

❑→ **Spinal: C ________________________ T ________________________ L ______________ P ________ S _________**

❑ **THERAPY** 1: MECHANICAL TRACTION (Cervical) Musculature: **Upper Traps, Splenius Capitus & Sternocleidomstoid**

Purpose: To restore the natural spinal curve, increase range of motion, decrease degeneration, mobilize the joints to help relieve nerve pressure.

Reps: 5-15

❑ **THERAPY** 2: MANUAL THERAPY→ Region(s): C T L P S Musculature: **Iliocostalis, Longissimus**

Purpose: Strengthen back muscles and improve core stability of the lower back region, increase range of motion as well as delivering nutrients to injured tissue, eliminating waste and rehydrate discs

❑ **THERAPY** 3: **DAKOTA TRACTION HOME UNIT** (Cervical)→ Region(s): Cervical Musculature**: : Upper Traps, Splenius Capitus & Sternocleidomstoid**

Reps: 5-10 secs → Increasing 10 min

Purpose: To restore the natural spinal curve, increase range of motion, decrease degeneration, mobilize the joints increase disc space, decrease segmental dysfunction, increase flexibility to help relieve nerve pressure. Decrease biomechanical alterations

❑ **THERAPY4: CERVICAL PILLOW** Yes

Purpose: To correct loss of cervical curve, improve proprioception, serve as neuromuscular reeducate, improve function and dampen chronic pain.

Time: Up to 15 min

PHASE I- II → Passive through Active Therapeutic Care
Ins: ________ Contract Price Per Visit: ___________ "Active Care for MMI" 6 12 18 24

❑A 3X **per week** for 8 Week(s) THEN → 2X per week for 12 weeks

Therapy 1	**3** X per week for 8 Week(s)
Therapy 2	**3** X per week for 8 Week(s)
Therapy 3	**2** X per week for 8 Week(s)

❑B 2X **per week** for 4 Week(s) THEN → 1X per week for **8** weeks

Therapy 1	**2** X per week for **4** Week(s)
Therapy 2	**2** X per week for **4** Week(s)
Therapy 3	**1** X per week for 4 Week(s)

Home Care → Recommendations /Instructions:

❑ **Ice-** applied to reduce inflammation and swelling.
❑ Heat**-** to improve circulation and bring nutrients to the injured area
❑ Rest - to avoid over use and further injury, minimize motion, overuse, and eliminate further stress to injured area.
❑Exercise- low back- stretches, postural movements, pelvic stabilizing, McKenzie back exercises.
cervical – range of motion exercise, gravity assisted resistive exercises, curve reinforcement stretches.
❑ Home Care kit
❑Other ____

Doctors Signature ____**Date:**________________________________

X-RAY REPORT

Patient Name: ___________________________ DOB:_________ HR#: ______________ Date of Study:___/___/___

( ) Male ( ) Female

Cervical Spine

( ) AP, Lateral ( ) Flexion/Extension ( ) Oblique ___*left* _____ *right*
( ) **NEGATIVE** for recent fracture or gross pathology; bodies, pedicles and disc spaces appear normal
( ) Lordotic Curve ( ) Mild decrease ( ) Severe decrease ( ) Kyphotic
( ) Scoliosis ( ) Left ( ) Right ( ) Mild ( ) Moderate ( ) Severe *Apex:* ________________
( ) Narrowed Disc Spaces between: ____
( ) Osteoarthritis of: ____
( ) Encroachment of Neuroforamina between: ____
( ) Hypertrophic Arthritic Change of ( ) Anterior ( ) Posterior level: ____
( ) End Plate Deformity of: ____
( ) Spina Bifida Level: ____
( ) Clinical Rationale for taking films:____
( ) Clinical Rationale for taking films to find the exact location of subluxation:____

Thoracic Spine

( ) AP, Lateral ( ) Oblique ___*left* ___ *right*
( ) **NEGATIVE** for recent fracture or gross pathology; bodies, pedicles and disc spaces appear normal
( ) Kyphotic Curve ( ) Mild increase ( ) Severe increase ( ) Lordotic
( ) Scoliosis ( ) Left ( ) Right ( ) Mild ( ) Moderate ( ) Severe *Apex*: ________________
( ) Narrowed Disc Spaces between: ____
( ) Osteoarthritis of: ____
( ) Encroachment of Neuroforamina between: ____
( ) Hypertrophic Arthritic Change of ( ) Anterior ( ) Posterior level: ____
( ) End Plate Deformity of: ____
( ) Spina Bifida Level: ____
( ) Clinical Rationale for taking films:____
( ) Clinical Rationale for taking films to find the exact location of subluxation:____

Lumbar Spine

( ) AP, Lateral ( ) Flexion/Extension ( ) Oblique ___*left* ___*right*
( ) **NEGATIVE** for recent fracture or gross pathology; bodies, pedicles and disc spaces appear normal
( ) Lordotic Curve ( ) Mild decrease ( ) Severe Decrease ( ) Kyphotic
( ) Scoliosis ( ) Left ( ) Right ( ) Mild ( ) Moderate ( ) Severe *Apex*: __________________
( ) Narrowed Disc Spaces between: ____
( ) Osteoarthritis of: ____
( ) Encroachment of Neuroforamina between: ____
( ) Hypertrophic Arthritic Change of ( ) Anterior ( ) Posterior level: ____
( ) End Plate Deformity of: ____
( ) Spondylolisthesis ( ) Grade 1 ( ) Grade 2 ( ) Grade 3 ( ) Grade 4 Level: ____________________________
( ) Calcified Abdominal Aorta ( ) Mild ( ) Moderate ( ) Severe
( ) Lumbarization of S1 Sacral Segment
( ) Sacralization of L5
( ) Hypertrophic arthritic change ( ) Anterior motor unit of: ____
( ) Posterior motor unit of: ____
( ) Sacroiliac Articulation ( ) Left ( ) Right ( ) Bilateral
( ) Acetabulum ( ) Left ( ) Right ( ) Bilateral
( ) Spina Bifida Level: ____
( ) Clinical Rationale for taking films to find the exact location of subluxation:____

( ) Check Here if more notes on back of this sheet

______________________________________ ______ - ______ - ______

Doctor's Signature **Date**