Chiropractic First, LLC

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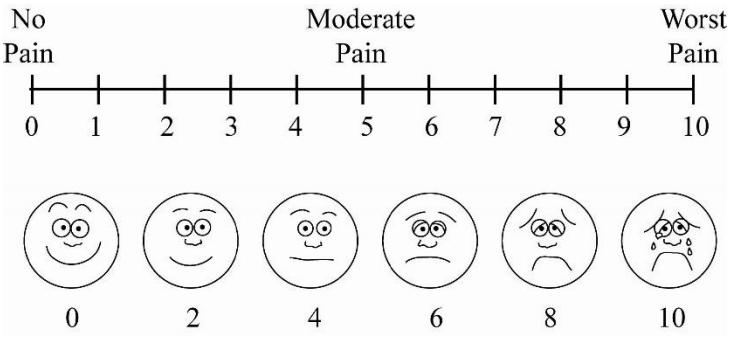
Patient Name:_____ Date:_____

Any new accidents, injuries, medications since your last adjustment: ◯ Yes ◯ No

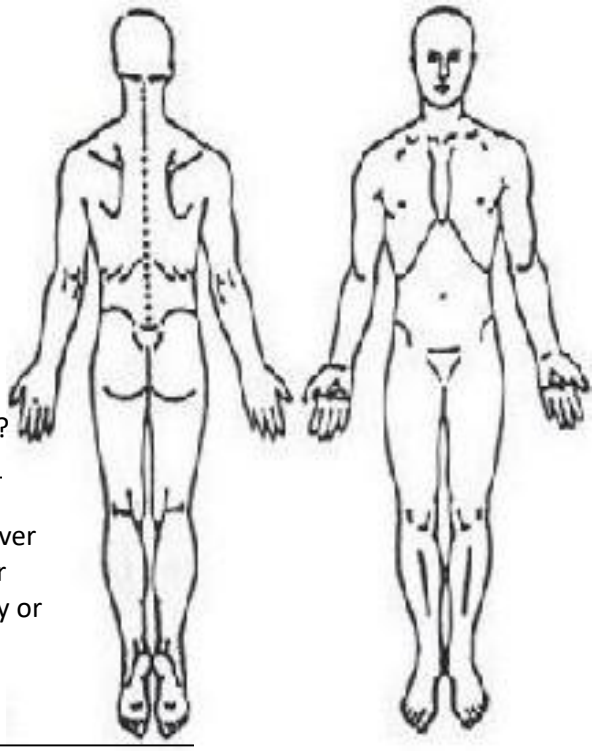
If Yes, please describe:_____

_____

Since your last adjustment are you feeling,
Better Same Worse
(Please circle one and mark below)



Please mark on X on the diagram below where you are having pain, numbness, tingling and/or spasms.



Has your billing information, phone number or address changed?
□Yes □ No :_____

We are happy to submit claims to your primary insurance, however Payment is expected at the time of service. Charges sent to your Insurance are your responsibility if the company has failed to pay or respond in 60 days.

Responsible Party Signature:_____

Subjective:_____

_____

Objective:_____

Muscle Spasm: ◯ Cervical_____ ◯ Thoracic_____ ◯ Lumbar_____

Cervical ROM_____ Lumbar ROM _____

Assess:_____

□Much Better □Some Improvement □Same □Worse □New Condition

Plan:_____

Treatment today consisted of manipulation: (Div/Cox/SOT_____)

Cervical 1 2 3 4 5 6 7 *Thoracic* 1 2 3 4 5 6 7 8 9 10 11 12 *Lumbar* 1 2 3 4 5

Ilium L R Sacrum Short Leg_____

Extremities:_____

Physiotherapeutic Modalities administered: □EMS_____ □U.S. _____□Interf_____

□Traction_____□Hot/Cold □Trigger Point Therapy/Other_____

Restrictions: □Limited Work □No Work □Lifting_____lbs. □Sitting, bending, standing

Recommendations: □Cervical, Lumbar Exercises □Ice Pack □Hot Compress □Other_____

_____

Dr. Jennifer Jozwiak, DC:_____ Date:_____ Revised 08/01/19