Chiropractic Office Name

DAILY VISIT NOTE

Patient's Name _____ Patient #: _____ Date: _____

Date this episode began: Visit #:	Medicare: ☐Acute ☐Chronic
Complaints/Conditions being treated with accompanying functional goals:	
#1 Complaint: Goal:	#3 Complaint: Goal:
#2 Complaint: Goal:	Notes:

#1 Complaint - Patient Stated:

S (P) :
☐Better ☐Same ☐Worse How? _____
☐Left ☐Right ☐Bilateral ☐Pain ☐Stiffness ☐Numb/Tingle ☐Mild ☐Mod ☐Severe ☐Intermittent ☐Frequent ☐Constant

O (ART) :
O=Ortho_____ ☐Asymmetry R/L_____ ROM: ☐Increased ☐Decreased ☐Same ☐Joint Restriction R/L_____
☐Edema R/L_____ ☐Spasm R/L_____ ☐Hypertonicity R/L_____ ☐Inflammation R/L_____
Other:

#2 Complaint - Patient Stated:

S (P) :
☐Better ☐Same ☐Worse How? _____
☐Left ☐Right ☐Bilateral ☐Pain ☐Stiffness ☐Numb/Tingle ☐Mild ☐Mod ☐Severe ☐Intermittent ☐Frequent ☐Constant

O (ART) :
O=Ortho_____ ☐Asymmetry R/L_____ ROM: ☐Increased ☐Decreased ☐Same ☐Joint Restriction R/L_____
☐Edema R/L_____ ☐Spasm R/L_____ ☐Hypertonicity R/L_____ ☐Inflammation R/L_____
Other:

#3 Complaint - Patient Stated:

S (P) :
☐Better ☐Same ☐Worse How? _____
☐Left ☐Right ☐Bilateral ☐Pain ☐Stiffness ☐Numb/Tingle ☐Mild ☐Mod ☐Severe ☐Intermittent ☐Frequent ☐Constant

O (ART) :
O=Ortho_____ ☐Asymmetry R/L_____ ROM: ☐Increased ☐Decreased ☐Same ☐Joint Restriction R/L_____
☐Edema R/L_____ ☐Spasm R/L_____ ☐Hypertonicity R/L_____ ☐Inflammation R/L_____
Other:

A (Assessment):
☐Same ☐Better_____% ☐Worse_____% ☐Treatment tolerated w/out incident _____ ☐Treatment tolerated well_____
Evidence of obj. funct. improvement: (How?) _____
Goals of further care: (Why?) _____

Circle 1-2-3 to match treatment rendered to complaint # noted above.

CMT 1 2 3	Hot+Cold 1 2 3 Time:_____	U/S 1 2 3 Time:_____	Massage 1 2 3 Time:_____
Technique _____	EMS 1 2 3 Time:_____	Laser 1 2 3 Time:_____	Thera. Exercises 1 2 3 Time:_____
CMT-Ext 1 2 3	Traction 1 2 3 Time:_____	Man. Therapy 1 2 3 Time:_____	Other: _____ 1 2 3 Time:_____

Seg. Adjusted: OCC C1 C2 C3 C4 C5 C6 C7 T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12 L1 L2 L3 L4 L5 Sac Pel RSI LSI Ext_____

Notes:

Signature of provider: _____ ☐ Schedule Re-Exam next visit

DAILY VISIT NOTE