TAYLOR-MADE HEALTH AND WELLNESS

Family Care ♦ Auto Accident Rehabilitation Therapy ♦ Wellness Care
WWW.TAYLOREDWELLNESS.COM

425 Citrus Tower Blvd Suite 301 Clermont, Florida 34711 Office: (352) 989-5555 Fax: (352) 432-2121

PATIENT REGISTRATION

NAME: _____ **D.O.B.** _____ **AGE**: _____

ADDRESS: _____ **CITY**: _____ **STATE**: _____ **ZIP**: _____

SEX: _____ **SOCIAL SECURITY#**: _____ **EMAIL**: _____

HOME PHONE: _____ **WORK PHONE**: _____

CELL PHONE: _____ ←CARRIER: _____NEEDED FOR APPT. REMINDERS

***WE SEND OUT APPT. REMINDER THROUGH EMAIL OR TEXT, WHICH DO YOU PREFER?**

(CHOOSE 2 BEST WAYS) □EMAIL □TEXT □PHONE □NONE.

***HOW DID YOU HEAR ABOUT US?**

□INTERNET □GYM □FRIEND □SIGN □FLYER □NEWSPAPER □OTHER:_____

IF REFERRED, WHO REFERRED YOU TO OUR OFFICE? _____

ATTORNEY (IF ANY): _____ **LOCATION**: _____

FINANCIAL RESPONSIBILITY

WHO IS RESPONSIBLE FOR THE BILL: □ INSURANCE □ MY EMPLOYER □ SPOUSE □ I AM □ OTHER

TYPE OF INSURANCE:□ AUTOMOBILE □ HEALTH □ WORKER COMP. □ CASH

INSURANCE COMPANY'S NAME: _____ **CLAIM#:** _____

MAILING ADDRESS: _____

DED: _____ **MED PAY**: _____ **COVERED**: _____%

ADJUSTER NAME: _____ **PHONE**: _____ **EXT**. _____

WE WILL NEED TO MAKE A COPY OF ID CARD AND INSURANCE CARD

INSURANCE MEDICAL RELEASE/ASSIGNMENT:

I hereby authorize release of Medical Information necessary to process my insurance claim to my insurance company and/or Attorney representing me. I also authorize payment of benefits to provide service. I understand that I am financially responsible for changes not covered by my insurance.

PATIENT SIGNATURE_____ **DATE**: _____

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PATIENT SIGN-IN REGISTER

PATIENT'S NAME_____ **DATE**_____

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Consent for Purpose of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by **TAYLOR-MADE HEALTH AND WELLNESS P.A.** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **TAYLOR-MADE HEALTH AND WELLNESS P.A..** I understand that diagnosis or treatment of me by **TAYLOR-MADE HEALTH AND WELLNESS P.A.** may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **TAYLOR-MADE HEALTH AND WELLNESS P.A.** is not required to agree to the restrictions that I may request. However, if **TAYLOR-MADE HEALTH AND WELLNESS P.A.** agrees to a restriction that I request, the restriction is binding on **TAYLOR-MADE HEALTH AND WELLNESS P.A.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **TAYLOR-MADE HEALTH AND WELLNESS P.A.** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **TAYLOR-MADE HEALTH AND WELLNESS P.A.'S** Notice of Privacy Practices prior to signing this document. **TAYLOR-MADE HEALTH AND WELLNESS P.A.'S** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **TAYLOR-MADE HEALTH AND WELLNESS P.A..** The Notice of Privacy Practices for **TAYLOR-MADE HEALTH AND WELLNESS P.A.** is also provided at the reception desk. This Notice of Privacy Practices also describes my rights and **TAYLOR-MADE HEALTH AND WELLNESS P.A.'S** duties with respect to my protected health information.

TAYLOR-MADE HEALTH AND WELLNESS P.A. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of me next appointment.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
TAYLOR-MADE HEALTH AND WELLNESS P.A.'s Representative

TAYLOR-MADE HEALTH AND WELLNESS

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ASSIGNMENT OF BENEFITS & CAUSE OF ACTION

I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to **TAYLOR-MADE HEALTH AND WELLNESS P.A.** ("Assignee"), such sums as may be due and owing Assignee for the services rendered to me, both by reason of accident or illness, and by reason of any other bills that are due Assignee and to withhold such sums from any disability benefits, medical payment benefits, No-Fault benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as maybe necessary to adequately protect said Assignee. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered. I hereby further give an irrevocable lien to said assignee against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment, or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee s services provided. In the event my Insurance company is obligated to make payments to me upon charges made by the Assignee for its services refuses to make such payments, upon demand by me or Assignee, I hereby assign and transfer to Assignee any and all causes of action, and proceeds from such causes of action, that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or Assignee's name and further I authorize Assignee to compromise, settle or otherwise resolve said claim of action as they see fit.

DIRECTION OF PAYMENT

I hereby authorize any Insurance company or attorney to pay directly to Assignee the amount of this and/or any future bills for services rendered to me. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to Assignee.

PIP LOG DEC SHEET REQUEST

I hereby authorize Assignee to release any information requested that is pertinent to my case to my insurance company or attorney involved in this case. Pursuant to §627.4 137 Florida Statutes (2001), I hereby request a copy of the pip log and declaration sheet, which reflects the policy limits available at the time of this accident, to be provided to Assignee. I hereby authorize Assignee to request and receive a copy of my pip log periodically as they deem to be necessary. If any term or provision of this Assignment, Lien and Authorization or the application thereof to any person or circumstances shall to any extent be invalid or unenforceable the remainder of this Assignment, lien and Authorization, or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and each term and provision of this Assignment, Lien and Authorization shall be valid and enforced to the fullest extent of the law.

RESERVATION OF BENEFITS

Please be advised that I am hereby placing you on notice that, pursuant to Florida case law, should you deny, reduce or fail to pay either a portion of or an entire bill submitted on my behalf from this healthcare provider, I am requesting that you reserve, or hold aside, that same amount until this dispute is resolved. Should you submit a check to this health care provider which is less than the correct contractual amount, and language referring to payments as "Full and Final Payment," I have instructed this health care provider to return the check to you (the carrier) and consider the bill still due and owing (i.e a late payment as defined in F.S 627.736). Additionally should the remaining amount of my benefits approach an amount where there would be inefficient funds to pay the amount you reduced, denied or failed to pay, please notify me (the assignor) and the assignee (this health care provider) of this fact. Lastly, should my benefits become exhausted; please notify me (the assignor) and this health care provider (the assignee).

NAME PRINT: _____

SIGNATURE: _____DATE_____

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Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I array be entitled to a portion of any reduction in the amounts paid *by my* motor vehicle insurer. If entitled, my share would be at **least** 20% of the amount of the reduction, up to $500.

Insured Person *(patient receiving treatment or services) or Guardian of Insured Person:*

_____ _____ _____

Name (Print) Signature Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered I above and also:

A.I have **not solicited** or caused the insured person, who was involved in *a motor vehicle accident, to* be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately,** and in a **substantially complete** manner.

D. *The* coding of procedures on the accompanying statement or bill is proper. This means that **no service has been armed, unbundled,** or constitutes an invalid **or not medically necessary diagnostic test** *as* defined by Section 627.732 (15) and (16), Florida Statutes or Section 6Z7.736(*5)(b) 6, Florida Statutes.*

Licensed Medical Professional Rendering Treatment/ Services or Medical Director, if applicable (Signature by his/ her ***own hand****):*

DR J.P. SILVERA DC _____ _____

Name (Print) Signature Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

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NOTICE OF INITIATION OF MEDICAL TREATMENT PURSUANT TO FLORIDA STATUTE 627.736

PATIENT_____ DATE OF LOSS ____/____/____
INSURANCE CO_____
CLAIM NUMBER_____

Dear Sir/Madam: Please be advised that the above medical provider is hereby giving notice pursuant to F.S. 627.736 of initiation of medical treatment within 21 days after first examination or treatment of the claimant. By giving the aforementioned notice, the medical provider may bill for charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the billing statement.

Very truly yours,

Billing Address:
Taylor-Made Health and Wellness 425 Citrus Tower Blvd Suite 301 Clermont, Florida 34711

OFFICIAL CERTIFICATION OF PATIENT AS TO INSURANCE COVERAGE

PATIENT_____ DATE OF LOSS ____/____/____
INSURANCE CO_____
CLAIM NUMBER_____

I, as the above captioned patient hereby attest that to the best of my knowledge, that the insurance claims information I have provided above is in fact the correct insurance information under which I am entitled to medical and/or PIP coverage.
I understand that the medical provider is relying on this correct information in order to receive the appropriate coverage and qualify for payment for medical services provided to me.

SIGNATURE_____ DATE_____/_____/_____

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Authorization for Use or Disclosure of Protected Health information

I authorize my physician and/ or administrative and clinical staff to (check all that apply):

_____ Use the following protected health information, and /or
_____ Disclose the following protected health information to **Name of entity or class of persons to receive information.**

Specifically and meaningfully describe the protected health information to be used or disclosed such as date of service, type of service, level of detail to be released, origin of information, etc.
This protected health information is being used or disclosed for the following purpose:
_____
_____

List specific purpose here. "At the request of the individual" is acceptable if the request is made by the patient, and the patient does not want to state a specific purpose.

This authorization shall be in force and effect until [specify (1) date or (2) event that relates to the patient or the purpose of the use of disclosure] at which time this authorization to use of disclose this protected health information expires. (" find of the research study" "and" none" is acceptable for authorization for research purposes.)

I understand that I have the right to revoke this authorization, in writing, at anytime by sending such written notification to the practice's Privacy Contact at [office address or e-mail address] understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be prosecuted by the federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party. [If applicable because the authorization is obtained for marketing purposes.]

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name of Patient of Personal Representative

_____
Description of Personal Representative's Authority

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To: _____

_____

_____

DOCTOR'S LIEN:

Re: Patient records and doctor's lien

I DO HEREBY authorize the above named facility/doctor to furnish you, my attorney, with a full report of its case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident which occurred on: _____ (DOA)

I DO HEREBY give a lien to said facility/doctor on any settlement, claim, judgment or verdict as a result of said accident, and authorize and direct you, my attorney, to pay directly to said facility/doctor such sums as may be due and owing him or her for services rendered to me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect said facility/doctor adequately.

I FULLY understand that I am directly and fully responsible to said facility/doctor for all bills submitted by it for services rendered to me, and that this agreement is made solely for said facility's/doctor's additional protection and in consideration for its awaiting payment.

Dated: _____ PATIENT'S Signature: _____

PRINT NAME: _____

THE UNDERSIGNED, being attorney of record for the above-named patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above-named facility/doctor.

Dated: _____ Authorized Signature: _____
ATTORNEY

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Birth Date: _____ Social Security No: _____

Release Records To: ___Taylor- Made Health and Wellness
(Name of Recipient) *return via fax (352)-432-2121*

Obtain Records From: _____
(Name of Requested)

_____
(Address)

_____
(City, State, Zip Code)

_____
(Phone and Fax Number)

Specific Records Requested:
Office Visits: _____ X-rays: _____ Labs: _____ All: _____

I consent to release information regarding Alcoholism and Drug Abuse. _____
(Initials)

I consent to release information regarding Mental Disorders and Rehabilitation. _____
(Initials)

I consent to release information regarding HIV, AIDS, and Sexually Transmitted Diseases.
_____
(Initials)

NOTE: Only a Limited Medical Summary will be sent if all of the above consents are not initialed.
Please Do Not Mail Films.

_____ _____
Patient or Legal Representative Signature Date

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AUTO ACCIDENT ONLY:

1. **When was the date of the accident?** _____
2. **What was your seating position in the vehicle at the time of the accident?**
   a. ☐Driver ☐Front passenger ☐Rear passenger
3. **What type of vehicle were you seated in during the accident?**
   a. ☐Car ☐Suv ☐Van ☐Truck ☐Motorcycle ☐Tractor Trailer
4. **Did you**? ☐Get hit by a vehicle ☐Hit a vehicle
5. **Where was the impact made on your vehicle?**
   a. ☐Front ☐Rear ☐Driver Side ☐Passenger Side
6. **What was your vehicle position status just before the impact?**
   a. ☐Stopped at intersection, ☐Stopped in traffic, ☐Slowing down, ☐Turning (L/R) ☐Proceeding along.
7. **What was the other vehicle type involved in the accident?**
   a. ☐Car ☐Suv ☐Van ☐Truck ☐Motorcycle ☐Tractor Trailer
8. **Were you wearing your seatbelt?** ☐Yes/☐ No
9. **Did secondary impact occur (Did you hit anything/one else)?** ☐Yes/☐ No
   a. **Was vehicle towed away after accident?** ☐Yes ☐No
10. **Did you vehicle have airbags?** ☐Yes/☐ No
    a. **If so did airbags deploy (inflate)?** ☐Yes ☐No
11. **Did your seat break (seat back failure)?** ☐Yes/☐ No
12. **What were visual conditions at time of accident? (check of all that apply)**
    a. ☐Clear ☐Foggy ☐Wet ☐Dark
13. **What were road conditions at time of accident? (check of all that apply)**
    a. ☐Dry ☐Sandy ☐Wet
14. **Were you anticipating collision?** ☐Yes ☐No
15. **Did you brace for impact of accident?** ☐Yes ☐No
16. **Did you lose consciousness?** ☐Yes ☐No
17. **Did you go to the Emergency room/Urgent care?** ☐Yes ☐No
18. **If so did you go by ambulance?** ☐Yes ☐No
19. **Did any part of your body make contact with interior structure in vehicle?**
    a. ☐Yes ☐No
    b. If so which body area? **(check of all that apply)**
       i. ☐Head ☐Back ☐Elbow (L/R) ☐Shoulder (L/R) ☐Wrist (L/R) ☐Hip (L/R) ☐Knee (L/R) ☐Ankle (L/R)
20. **Which part of the vehicle? (check of all that apply)**
    a. ☐Steering Wheel ☐Dashboard ☐Gear Shifter ☐Door ☐Headrest ☐Other

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1. WHERE IS AREA OF CONCERN: _____(/10)

What does pain feel like?

☐Spasm ☐Numbing ☐Burning ☐Tingling ☐Throbbing ☐Aching ☐Other:_____

How often do you experience symptoms:

☐ Constant(100%-75%) ☐Frequent(74%-51%) ☐Occasionally(50%026%) ☐Intermittently(25%-0%)

What makes pain feel "better?"

☐Nothing ☐Rest ☐Walking ☐Stretching ☐Exercise ☐Other:_____

What makes pain fell "worse?"

☐Bending ☐Twisting, ☐Lifting ☐Sitting ☐Standing ☐Coughing ☐Temp. Changes

Does Pain Radiate (Move) to another part of the body? ☐Yes ☐ No

This pain: ☐is a new pain ☐I've had before, but went away ☐already had but now it is worse

2. WHERE IS AREA OF CONCERN: _____(/10)

What does pain feel like?

☐Spasm ☐Numbing ☐Burning ☐Tingling ☐Throbbing ☐Aching ☐Other:_____

How often do you experience symptoms:

☐ Constant(100%-75%) ☐Frequent(74%-51%) ☐Occasionally(50%026%) ☐Intermittently(25%-0%)

What makes pain feel "better?"

☐Nothing ☐Rest ☐Walking ☐Stretching ☐Exercise ☐Other:_____

What makes pain fell "worse?"

☐Bending ☐Twisting, ☐Lifting ☐Sitting ☐Standing ☐Coughing ☐Temp. Changes

Does Pain Radiate (Move) to another part of the body? ☐Yes ☐ No

This pain: ☐is a new pain ☐I've had before, but went away ☐already had but now it is worse

3. WHERE IS AREA OF CONCERN: _____(/10)

What does pain feel like?

☐Spasm ☐Numbing ☐Burning ☐Tingling ☐Throbbing ☐Aching ☐Other:_____

How often do you experience symptoms:

☐ Constant(100%-75%) ☐Frequent(74%-51%) ☐Occasionally(50%026%) ☐Intermittently(25%-0%)

What makes pain feel "better?"

☐Nothing ☐Rest ☐Walking ☐Stretching ☐Exercise ☐Other:_____

What makes pain fell "worse?"

☐Bending ☐Twisting, ☐Lifting ☐Sitting ☐Standing ☐Coughing ☐Temp. Changes

Does Pain Radiate (Move) to another part of the body? ☐Yes ☐ No

This pain: ☐is a new pain ☐I've had before, but went away ☐already had but now it is worse

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When does pain(s) cause you difficulty while doing your normal daily routines?

(Check of all that apply)

☐Bathing ☐Dressing ☐Grooming ☐Oral care ☐Toileting ☐Transferring ☐Walking ☐Climbing stairs ☐Eating ☐Shopping ☐Cooking ☐Managing medications ☐Using the phone ☐Housework ☐Doing Laundry ☐Driving managing finances

Past Medical History: **(check of all that apply)**

☐None ☐Abnormal spine curvature ☐Congenital spine abnormalities ☐Degenerative disc disease ☐Arthritis ☐Spine surgery ☐Diabetes ☐Auto Accident ☐ Other_____

Past Surgical History: (*Please indicate year)

☐None ☐Brain ☐Back ☐Elbow (L/R) ☐Shoulder (L/R) ☐Wrist (L/R) ☐Hip (L/R) ☐Knee (L/R) ☐Ankle (L/R)

Occupational History:

Are you employed? ☐Yes ☐No what is you Occupation? _____

Have you lost time from work from this pain? ☐Yes ☐ No

Family History: **(check of all that apply)**

☐None ☐Abnormal spine curvature ☐Congenital spine abnormalities ☐Degenerative disc disease ☐Arthritis ☐Spine surgery ☐Diabetes ☐Auto Accident ☐ Other_____

Allergies: **(check of all that apply)**

☐Penicillin ☐Sulfa ☐Aspirin ☐Latex ☐Amoxicillin ☐Latex ☐Other:_____

Medications: (Please List)

1. _____ 2. _____ 3._____

Social History:

☐Married ☐Single ☐Widowed ☐Divorced ☐Smoke ☐Alcoholic Drinking

Are you seeing any other doctors treating you for this condition?

☐Yes ☐No, If yes Who_____

Have you ever received chiropractic care?

☐Yes ☐No, If Yes who_____

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Brain Injury Assessment: (Check all that apply)

☐Don't feel normal ☐Nervous or anxious ☐Sad ☐Irritable ☐More emotional ☐Trouble falling asleep ☐Confusion ☐Fatigue or low energy ☐Difficulty remembering ☐Nausea ☐Difficulty concentrating ☐Feeling like a fog ☐Feeling slowed down ☐Sound sensitivity ☐Light sensitivity ☐Balance problems ☐Blurred vision ☐Vomiting ☐Pressure in head ☐Headache ☐Dizziness ☐Don't feel right ☐ Drowsiness

Review of systems: (Check of all that apply)

☐ Unexpected Weight Gain or Loss ☐Fatigue ☐Fever chills ☐Rashes ☐Head Injury ☐Ringing in Ears ☐Vision Loss/changes ☐Discharge ☐Bleeding ☐Lumps ☐Coughing up blood ☐Shortness of breath ☐Chest pain or discomfort ☐Shortness of breath with activity ☐Sudden awakening from sleep with shortness of breath ☐Swallowing difficulties ☐Change in appetite ☐Constipation ☐Diarrhea ☐Blood in urine ☐Redness of joints ☐Swelling of joints ☐Tremor

OFFICE USE:

VITALS: _____/_____ BP **PULSE:_____**

PAIN:
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.-Pelv.
Extremity: ☐ Shoulder L/R/B ☐ Elbow: L/R/B ☐ Wrist: L/R/B ☐ Hand: L/R/B ☐ Hip: L/R/B ☐ Knee: L/R/B ☐ Ankle: L/R/B ☐ Foot: L/R/B

SPASM:
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.-Pelv.
Extremity: ☐ Shoulder L/R/B ☐ Elbow: L/R/B ☐ Wrist: L/R/B ☐ Hand: L/R/B ☐ Hip: L/R/B ☐ Knee: L/R/B ☐ Ankle: L/R/B ☐ Foot: L/R/B

ROM:
Cervical (Inc./ Norm./Dec.) Thoracic (Inc./ Norm./Dec.) Lumbar(Inc./ Norm./Dec.)

ORTHOPEDIC EXAM:

Cervical:
Cervical Distraction :(+/-)(L/R/B)
Shoulder Depression :(+/-)(L/R/B)
Max. Cervical Compression :(+/-)(L/R/B)
Valsalva's :(+/-)(L/R/B)

Lumbar:
Kemp's :(+/-)(L/R/B)
Straight Leg Raise :(+/-)(L/R/B)
Braggard's Test :(+/-)(L/R/B)
Milgrams :(+/-)(L/R/B)

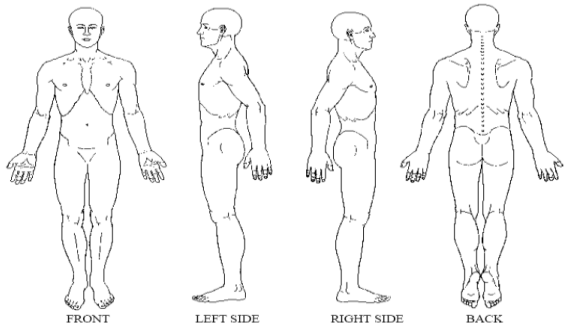
MOTOR
(LEFT) C5__/5, C6__/5, C7__/5, C8__/5 L4__/5, L5__/5, S1__/5 (RIGHT) C5__/5, C6__/5, C7__/5, C8__/5, L4__/5, L5__/5, S1__/5

REFLEX
(Left) C5__/5, C6__/5, L5__/5 (RIGHT) C5__/5 C6__/5 5 L5__/5

REFERRALS: ☐ ORTHO ☐ NEURO ☐ PAIN MANAGEMENT

PROGNOSIS ☐ Poor ☐ Fair ☐ Guarded ☐ Good ☐ Excellent

INITIAL THERAPIES:
☐ E-STIM ☐TRACTION ☐UTRASOUND ☐COLD/HOT ☐BIOFREEZE
☐ COLD LASER ☐ STRETCHING ☐KINETIC ☐MANUAL ☐ SPINAL DECOMPRES



☐RECORDS REQUEST _____ ☐M.D._____

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DIAGNOSTIC: □ XRAY: 1.____ 2.____ 3.____ □ MRI: 1.____ 2.____ 3.____ 4.____

Patient Name:_____ Date:_____

- □ R51---------Headache
- □ M53.1------Cervicobrachial syndrome
- □ M54.12-----Radiculopathy, cervical region
- □ M54.16-----Radiculopathy, lumbar region
- □ S13.4XXA-Sprain of ligaments of cervical spine, **initial encounter**
- □ S23.3XXA-Sprain of ligaments of thoracic spine, **initial encounter**
- □ S33.5XXA-Sprain of ligaments of lumbar spine, **initial encounter**
- □ S16.1XXA-Strain of muscle, fascia and tendon at neck level, **initial encounter**
- □ S39.012A--Strain of muscle, fascia and tendon of low back, **initial encounter**
- □ S43.421A--Sprain of right rotator cuff capsule**, initial encounter**
- □ S46.011A--Strain of muscles and tendon of rotator cuff of right shoulder, **initial encounter**
- □ S43.422A--Sprain of left rotator cuff, **initial encounter**
- □ S46.012A--Strain of muscles and tendon of rotator cuff of left shoulder, **initial encounter**
- □ M99.01-----Segmental and somatic dysfunction of cervical region
- □ M99.02-----Segmental and somatic dysfunction of thoracic region
- □ M99.03-----Segmental and somatic dysfunction of lumbar region
- □ M99.05-----Segmental and somatic dysfunction of pelvic region
- □ M54.2------Cervicalgia
- □ M54.6------Pain in Thoracic spine
- □ M54.5------Low back pain
- □ M62.830---Muscle spasm