Miracles Health Care Center

TOTAL BODY RELEASE CHIROPRACTIC CARE

Office Visit Exit Form

Date of Visit: ____/____/_____ Last Name: _____ First _____ M.I. ____

(Circle one for each complaint) **Pain Scale**: None Moderate Extreme Pain

Complaints:											
1. _____	0	1	2	3	4	5	6	7	8	9	10
2. _____	0	1	2	3	4	5	6	7	8	9	10
3. _____	0	1	2	3	4	5	6	7	8	9	10

Diagnostic Testing: ROM MT Cervical Lumbar Extremity: _____

The patient entered the office today and reported the following:

- ☐ Headache
- ☐ Neck Pain/Stiffness
- ☐ Upper Back Pain/Stiffness
- ☐ Mid-Back Pain/Stiffness
- ☐ Lower Back Pain/Stiffness
- ☐ Shoulder Pain

☐ Weakness:	☐ Arms	☐ Legs	☐ Hands
☐ Pins & Needles:	☐ Arms	☐ Legs	☐ Hands
☐ Numbness:	☐ Arms	☐ Legs	☐ Hands

Pain Radiating Into:

☐ Hand	☐ L	☐ R	☐ Both
☐ Arm	☐ L	☐ R	☐ Both
☐ Shoulder	☐ L	☐ R	☐ Both
☐ Hip	☐ L	☐ R	☐ Both
☐ Chest	☐ L	☐ R	☐ Both
☐ Leg	☐ L	☐ R	☐ Both
☐ Foot	☐ L	☐ R	☐ Both

Examination~ Motion & Static Palpation Revealed the following:

Patient has difficulty in:		Restrictive ROM	Muscle Spasms
☐ Lifting	☐ Sitting	☐ Cervical Spine	☐ Mild ☐ Mod ☐ Sev
☐ Standing	☐ Bending	☐ Thoracic Spine	☐ Mild ☐ Mod ☐ Sev
☐ Sleeping	☐ Walking	☐ Lumbar Spine	☐ Mild ☐ Mod ☐ Sev
☐ Rising From Bed/Chair		☐ Pelvic Region	☐ Mild ☐ Mod ☐ Sev
☐ Daily Activities		☐ Shoulder	☐ Mild ☐ Mod ☐ Sev
☐ Other:_____		☐ Knee	☐ Mild ☐ Mod ☐ Sev
		☐ Ankle / Foot	☐ Mild ☐ Mod ☐ Sev
Derifield Leg Check:		☐ Short Left	☐ Short Right

Vertebral Tenderness & Fixations

	L	R		L	R		L	R		L	R		L	R		L	R
C1	☐	☐	Occ	☐	☐	Jaw	☐	☐	L1	☐	☐	1st Rib	☐	☐	Clr Bn	☐	☐
C2	☐	☐	T1	☐	☐	T7	☐	☐	L2	☐	☐	Shoulder	☐	☐	Scpula	☐	☐
C3	☐	☐	T2	☐	☐	T8	☐	☐	L3	☐	☐	Elbow	☐	☐	Hip Jt	☐	☐
C4	☐	☐	T3	☐	☐	T9	☐	☐	L4	☐	☐	Wrist	☐	☐	Knee	☐	☐
C5	☐	☐	T4	☐	☐	T10	☐	☐	L5	☐	☐	Hand	☐	☐	Ankle	☐	☐
C6	☐	☐	T5	☐	☐	T11	☐	☐	IL	☐	☐	Pubic Bn	☐	☐	Foot	☐	☐
C7	☐	☐	T6	☐	☐	T12	☐	☐	SAC	☐	☐	Stomach	☐	☐	Sinus	☐	☐

Doctor's Notes: _____

_____

_____

ASSESSMENT: Response from last visit: ☐ Better ☐ Same ☐ Worse ☐ Initial Visit

Overall Response: ☐ Progressing Satisfactorily ☐ Progressing Slowly ☐ Not Improved ☐ Erratic Response

☐ Aggravated by recent physical activity ☐ Exacerbated ☐ Resolved

TREATMENT PLAN

☐ Continue with current corrective treatment	☐ Adjustment	☐ Traction	☐ Moist Heat
☐ Change frequency of visits	☐ Ice	☐ Ultrasound	☐ Diathermy
☐ Addition to treatment plan	☐ Electric Stimulation	☐ Myofascial Release	☐ Manual Therapy
☐ Remove from treatment plan	☐ Lumbar Support	☐ Cervical Collar	☐ Therapeutic Exercise
☐ Move from corrective to maintenance care	☐ Neuromuscular Reeducation		
☐ Release from care, max improvement			
☐ Discontinue care, patient's choice			

FREQUENCY

☐ Daily	☐ 3x/wk	☐ 2x/wk	
☐ 1x/wk	☐ 2x/mo	☐ 1x/mo	☐ PRN

OFFICE VISIT	**DISCRIPTION**		
☐ New Patient, Comprehensive	☐ CMT, 1-2 areas	☐ Neuromuscular Reeducation	☐ Electrical Stimulation (unit)
☐ Est. Patient, Problem Focused	☐ CMT, 3-4 areas	☐ Therapeutic Exercise	☐ Electrical Stimulation (manual)
	☐ CMT, 5 areas	☐ Manual Therapy	☐ Hot/ Cold Packs
	☐ CMT, extra spinal	☐ Mechanical Traction	☐ Biofreeze ☐ Supplements

FEES:			
☐ **0.5 Hour $45.00**	☐ **1 Hour $75.00**	☐ **1.5 Hours $105.00**	☐ **2 Hours $135.00**

Patient's Signature: _____ **Today's Total Fees: $**_____

Doctor's Signature: _____ **Date:** _____

804 Central St. W., Bagley, MN
224 2nd Ave. S.E., Clearbrook, MN
www.doc-mari.com

Contact: Dr. Mari Schwartz D.C.
Phone: (320) 339-0477
Email: docschwartzdc@gmail.com