Medical History Information

Name:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)
Email:			Single / Mar / Div / Widow

Height: ___ft. ___in. /**Weight:** ____lbs./**Dominant Hand:** ☐ Right ☐ Left	**Birth date:**	**Age:**	**Sex:**
Address:	**City:**	**State:**	
ZIP Code:	**Social Sec. No.:**	**Home Phone:**	
Occupation:	**Employer:**	**Work Phone:**	**Cell phone:**

Medical Care Information

Do You Have a Family Doctor?: ☐ No ☐ Yes, Name of Doctor:

Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		

Do You Have a Family Chiropractor?: ☐ No ☐ Yes, Name of Chiropractor:

Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		

Have you had surgeries: ☐ Yes ☐ No If yes, please list reasons and approximate dates below:

Reason for Surgery:

Present illness /Conditions:

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	☐
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	☐
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐

Other:

Family History of illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitus

Other:

Type of Cancer: ☐ Breast ☐ Lung ☐ Other:

Social History:

Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous

Smoking: ❑ Current every day smoker ❑Current some day smoker ❑Former smoker ❑ Never

(FEMALE PATIENTS) Is there a possibility of you being **PREGNANT** ? ☐ No ☐ Yes

PLEASE PROCEED TO THE BACK OF THIS PAGE AND FILL OUT ANY CURRENT MEDICATION INFORMATION

Medication Allergies					
☐ ACE Inhibitors	☐ Cephalosporin's	☐ HMG-COA Reductase Inhibitors	☐ Macrolides	☐ Paxil	☐ Sertraline Derivatives
☐ Amoxicillin	☐ Cipro	☐ Ibuprofen	☐ Mepridine	☐ Penicillin	☐ Sulfa
☐ Aspirin	☐ Codeine	☐ Iodine	☐ Metronidazole	☐ Percocet	☐ Tetracycline
☐ Bactrim	☐ Darvon	☐ Keflex	☐ Morphine	☐ Pravachol	☐ Ultram
☐ Benadryl	☐ Demerol	☐ Levaquin	☐ NSAIDS	☐ Propoxyphene	☐ Zestril
☐ Biaxin	☐ Erythromycin	☐ Lipitor	☐ Opioid Analgesics	☐ Quinolones	☐ Zocor
☐ Cefaclor	☐ Flagyl	☐ Lisinopril	☐ Peroxitine Derivatives	☐ Salicylates	☐ Zoloft
Other: What are the reactions you face? (i.e. - Hives, Rash, etc.)					

Medications					
Medication Name	**Dose**	**Form**	**Route**	**Frequency**	**Date Started**
E.G. Zyrtec	10 mg	Tablet	By mouth	once per day	10/24/2008

Race: ❑ White ❑African American ❑Asian ❑ Am Indian or AK Native ❑Native Hawaiian or other Pacific Islander ❑Decline

Ethnicity: ❑Non-Hispanic or Latino ❑Hispanic or Latino ❑Decline

Preferred Language: ❑English ❑Spanish ❑Portuguese ❑Italian ❑French ❑Chinese ❑Russian ❑Japanese

Preferred Contact: ❑Phone ❑Email ❑Text ❑Fax ❑Postal Mail ❑Other: _____

Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Motor Vehicle Accident Information

Last Name:	Social Security no.:
First Name:	Middle:

General Information

Date of Accident:			
Location (circle your position)	**Driver (Only Circle Here if You Were The Driver)**		
	Passenger	Location (circle one)	Front / Middle / Rear
		Position (circle one)	Left / Middle / Right

Work from Left to Right and Circle One

Patients Vehicle	**Type :**	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Action :	Stopped / Slowing / Acceleration / Cruising
	Speed : (MPH**)**	
	Time of Accident:	Day Light / Dawn / Dusk / Dark
	Road Condition :	Dry / Damp / Wet / Snow / Ice
	Visibility :	Good / Fair / Poor

Enter impact Information for up to three Vehicles or Objects

Impact Information: Vehicle or Object (I) (The Vehicle that Hit You)

(Select one) ☐ **Vehicle** ☐ **Object**	**Name Object :**	
	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Damage to Veh.:	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location on <u>Your</u> Vehicle		

Impact Information: Vehicle or Object (II)

(Select one) ☐ **Vehicle** ☐ **Object**	**Name Object :**	
	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Damage to Veh.:	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location		

Impact Information: Vehicle or Object (III)

(Select one) ☐ **Vehicle** ☐ **Object**	**Name Object :**	
	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Damage to Veh.:	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location		

During Impact Information:

Seat Belt?	☐ Yes	☐ No	Brakes Applied ?	☐ Yes	☐ No
Air Bag Deployed?	☐ Yes	☐ No	Seat Broken ?	☐ Yes	☐ No
Head Rest:	☐ Low	☐ Mid	☐ High	☐ None		
Seat Back Position Change	☐ Yes	☐ No				
Prepare for Accident:	☐ Un-expected	☐ Expected	☐ Expected and Braced			
Body Position:	☐ Straight	☐ Rotated Left	☐ Rotated Right	☐ Unsure	☐ Other:	
Body Thrown?	☐ Yes /	☐ No				
Direction of Throw :	☐ Backwards	☐ Forward	☐ Outside	☐ Unsure	☐ Other:	

Head Position :	☐ Straight ☐ Rotated Left ☐ Rotated Right ☐ Forward ☐ Unsure ☐Other:
Head Motion :	☐ Forward Backwards ☐ Backwards Forward ☐ Right Left ☐ Left Right ☐ Unsure ☐ Other:

Body Impact (Indicate any parts of your body that were struck during the impact)

☐ Head	☐ Upper Back	☐ Right hand	☐ Lower Back
☐ Left Shoulder	☐ Left Leg	☐ Mid Torso	☐ Right Foot
☐ Left Arm	☐ Right Leg	☐ Mid Back	☐ Left Foot
☐ Left Elbow	☐ Right Shoulder	☐ Right Knee	☐ Other :
☐ Left hand	☐ Right Arm	☐ Left Knee	
☐ Upper Front Torso	☐ Right Elbow	☐ Lower Front Torso	

After Impact / Accident Information:

Immediately After Accident:	☐ Dizzy/dazed ☐ Upset ☐ Weak ☐ Nervous ☐ Headache ☐ Disoriented ☐ Unconscious ☐/Other:

Pain (Indicate if you experienced any pain immediately following the accident)

☐ Head	☐ Left foot	☐ Right Shoulder	
☐ Neck	☐ Left Shoulder	☐ Left Arm	
☐ Left Hand	☐ Left Elbow	☐ Right elbow	
☐ Right Arm	☐ Mid Torso	☐ Lower Front Torso	☐ Other
☐ Upper Front Torso	☐ Mid back	☐ Lower Back	
☐ Upper Back	☐ Right Leg	☐ Left Knee	
☐ Left Leg	☐ Right foot	☐ Right knee	

Numbness:	☐Left Hand ☐ Right Hand ☐ Left Leg ☐ Right Leg ☐ Left Upper Arm ☐ Right Upper Arm ☐ Left Foot ☐ Right Foot ☐ Other:

Medical Information (Did you get medical care for this accident **before coming to our office**)

Medical Care?	☐ Yes	☐ No			
Time of care	☐ Next day	☐ At time of Accident	☐ Later that Day	☐ Days Later: (Specify #) _____	
Transported	☐ Drove Self	☐ Ambulance	☐ Other:		
Went To	☐ Orthopedic	☐ Chiropractor	☐ Neurologist	☐ Family Doc	☐ ER ☐ Other:(Specify)
Admitted to Hospital?	☐ Yes	☐ No	Days Spent in Hospital:		
Test:	☐ X-ray	☐ Lab Work	☐ MRI	☐ CT Scan	☐ Other:(Specify)
Treatment:	☐ Ice Pack	☐ Hot Pack	☐ None	☐ Cervical Collar	☐ Medication ☐ Other:(Specify)

Previous Injuries

Previous Injuries / Accidents	☐ No ☐ Yes, Specify:
Residual pain from Previous Injuries/Accidents	☐ No ☐ Yes, Specify:

Later Symptoms (Please note any symptoms that started after the accident occurred)

Head	☐ Headache ☐ Loss of Memory ☐ Light Headedness ☐ Other Specify: ☐ Fainting ☐ Blurred Vision ☐ Double Vision ☐ Dizziness ☐ Pain in ear ☐ Loss of Vision
Neck (with Movement)	☐ Pain in Neck ☐ Forward ☐ Backward ☐ Turn Left ☐ Other Specify: ☐ Muscle Spasms ☐ Turn Right ☐ Bend Left ☐ Bend Right ☐ Popping in Neck
Shoulders	☐ Pain in Shoulder joint ☐ Tension in shoulders ☐ Can't Raise Arms: ☐ Pain across shoulder ☐ Muscle Spasms in Shoulder [ ] Above shoulder level [ ] Over head ☐ Other Specify:
Mid back	☐ Sharp Stabbing ☐ Mid pain back ☐ Pain from front to back ☐ Other Specify: ☐ Dull Ache ☐ Muscle Spasms ☐ Pain between shoulders ☐ Pain in Kidney Area
Lower Back	☐ Low Back Pain ☐ Muscle Spasms in lower back Low back pain is worse when ☐ Working ☐ Lifting ☐ Stooping ☐ Standing ☐ Sitting ☐ Bending ☐ Coughing ☐ Lying Down ☐ Other Specify:
Hips, Legs & Feet	☐ Pain in Buttocks ☐ Pain and needles in Legs ☐ Pain down leg ☐ Pain in hip joint ☐ Feet feel Cold ☐ Swollen Feet ☐ Numbness in Toes ☐ Numbness of Leg ☐ Knee pain ☐ Leg cramps ☐ Cramps in Feet ☐ Other Specify:
Arms and Hands	☐ Pain in Fingers ☐ Numbness in Left Arm ☐ Other: ☐ Pin & needles in hands ☐ Numbness in Right Arm ☐ Pin & needles in fingers ☐ Cold Hands ☐ Swollen joints in Fingers ☐ Loss of Grip Strength
Chest	☐ Chest pain ☐ Pain Around Ribs ☐ Shortness of Breadth ☐ Breast Pain ☐ Other Specify:
Abdomen	☐ Nervous Stomach ☐ Nausea ☐ Diarrhea ☐ Gas ☐ Constipation ☐ Other Specify:
General	☐ Nervousness ☐ Fatigue ☐ Irritable ☐ Depressed ☐ Generally Feel Rundown ☐ Prostate Pain/Swelling ☐ Difficulty Urinating ☐ Night Urination Problems ☐ Cramping ☐ Irregularity Loss of Sleep : [_____] hrs per night Loss of weight : [_____]lbs Gain weight : [_____] ibs Other:

Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

FINANCIAL RESPONSIBILITY AGREEMENT

NAME _____ S.S. # _____

DATE OF BIRTH _____ ADDRESS _____

APT.#_____ CITY _____STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

This certifies that the above named individual agrees to pay in full for all professional services rendered at the time they are performed, unless other arrangements are made in advance of the set appointment. The below named guarantor understands a $ 10.00 returned check fee will be charged along with any appropriate collection or attorney's fee which may accrue upon collection of any outstanding balance.

A photocopy of this assignment shall be considered as effective and valid as the original

Please Check one of the following:

Payment to this Office by:
- ☐ Cash
- ☐ Check
- ☐ Credit Card
- ☐ Health Insurance
- ☐ Automobile Insurance

Privacy:

The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the *Health Insurance Portability and Accountability Act* of 1996 ("HIPPA") A major goal of the Privacy Rule is to assure that individual's health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPPA guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party.

I have read and understand the foregoing.

_____ _____

Date Policyholder/Guarantor

LifeForce CHIROPRACTIC

Jeff and Adriana MonteLeon, D.C.
5560 Babcock Street NE, Palm Bay, FL 32907
Phone: 321-409-0209 Fax: 321-409-0208

Doctor-Patient Relationship in Chiropractic

Chiropractic:

It is important to be an aware and an informed patient. We have found that an honest, open understanding of chiropractic care is helpful in order to bring about your potential for maximum health.

Your body has a potential to function at 100%. Our goal in chiropractic is to achieve better communication between the brain and the rest of the body through a fully functioning nervous system thus allowing the body the potential to function at 100%. We achieve this through chiropractic adjustments which correct spinal nerve interference called vertebral subluxations. When a vertebral subluxation is present in the spine the body is unable to function at 100% thus sickness and disease occurs.

When a chiropractic adjustment is provided by the chiropractor, the body is able to approach its potential to express optimum health. This is because of better communication though the nervous system by the reduction and correction of the vertebral subluxation and its related components. Rather that treat the resulting disease or your symptoms, chiropractors correct the spinal subluxation and the resulting nerve interference which is the number one cause of why the body functions at less than 100%. Instead of masking the symptoms with medications chiropractors look for the cause and correct the cause of your symptoms.

Analysis:

You will under go a chiropractic examination for the detection of vertebral subluxations and their related components. During the examination the chiropractor will evaluate how the spine moves, what it feels like and based upon the results of the examination findings X-rays of the spine may be performed. These X-rays will tell the doctor how far the vertebra is misaligned and in what direction. The X-rays will also help determine the most efficient chiropractic technique to effectively adjust and correct the spinal subluxations.

Diagnosis:

Only a chiropractor can determine if your case is a chiropractic case. Medical doctors diagnosis disease, chiropractors diagnose vertebral subluxations. Your diagnosis in this clinic will reflect spinal nerve interference which is caused by vertebral subluxations. Our doctors will work with any other health care provider for your benefit. Inversely, you should expect all other health care providers to work together with your chiropractor for your benefit. This team approach to your health care will benefit you the patient the best.

Chiropractic Adjustments:

The patient, in coming to the chiropractor, gives the chiropractor permission and authority to adjust the patient for spinal subluxations. In rare cases, under physical defects, deformities, or pathology may render the patient susceptible to injury. The chiropractor, of course, will not provide chiropractic adjustments if he is aware of any such conditions. If the patient is aware of any latent pathological defects, illness or deformities which would not otherwise come to the attention of the chiropractor, it is their responsibility to notify the chiropractor. The patient should not look to the

chiropractor for in depth diagnostic procedures. The chiropractor provides a specialized health service in the detection and correction of the vertebral subluxation and its related components. Any risks regarding chiropractic treatment will be explained upon request.

Although we use an OPEN ADJUSTING FORMAT, your confidential concerns can be handled appropriately, in specially designated private areas, for discussions with the Doctor, as long as a request is made in advance, and the sufficient time to handle your concern is scheduled.

Results

No doctor can promise a cure or guarantee results. The purpose of Chiropractic care is to promote natural health through the release of maximum nerve energy. Since there are so many variables, it is difficult to predict the time schedule or efficiency of chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory. In some it is only partial or not at all. Regardless of the disease,' the Chiropractor is not offering to heal, treat or cure it.

A major premise in chiropractic is that the body is a self healing organism and by removing the vertebral subluxation, hence the nerve interference it can function as close to 100% as possible. However, you must remember that there is no process that does not take time, this includes the healing process. The longer the problems been in the body the longer healing process will take the body. The chiropractor's goal is to allow the body to express health at its optimum without nerve interference. This goal is accomplished through the chiropractic adjustment by the correction of the vertebral subluxation. In order to facilitate a more effective level of understanding of the Chiropractic approach, a **New Patient Orientation** has been developed, and it is a required component for all new patients to attend. This requirement can be fulfilled prior to, or after initiating care. The seminar is also open to family and friends seeking a better understanding of basic Chiropractic concepts.

Privacy:

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You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPPA guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party. Our privacy policy is posted in the reception area and is available at the front desk upon your request.

Questions

Just as in a good marriage, proper communication is an absolute necessity. We want to help you attain your goal of health. If at any time your response is not satisfactory, we will gladly assist you in choosing a referral doctor for another opinion. Your health is our number one priority.

Acknowledgement:

I have read and understand the foregoing.

Signature _____ Date _____

Witness _____

LifeForce CHIROPRACTIC

Jeff and Adriana MonteLeon, D.C.

5560 Babcock Street NE, Palm Bay, FL 32907
Phone: 321-409-0209 Fax: 321-409-0208

ASSIGNMENT, LIEN AND AUTHORIZATION

I hereby authorize you, my insurance company and/ or attorney to pay directly to LifeForce Chiropractic, Inc., such sums as may be due and owing ***Assignees*** for services rendered by me, both by reason of accident or illness, and by reason of any other bills that are due ***Assignees,*** and to withhold such sums for any disability benefits, medical payments, No Fault benefits, or any other insurance benefits obligated to reimburse or from any settlement, judgment, or verdict on my behalf as may be necessary to adequately protect said ***Assignees.*** I hereby further give a lien to said ***Assignees*** 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 ***Assignees.*** This is to act as an assignment of my right and benefits to extent of the ***Assignees*** services provided and in accordance with Florida Statute 627.736.5

In the event my insurance company obligated to make payments to me upon charges made by ***Assignees*** for services, refuses to make such payments, upon demand by me or ***Assignees***, I hereby assign and transfer ***Assignees*** any and all causes of action that I might have or that exists in my favor against such company and authorize ***Assignees*** to prosecute said causes of action either in my name or in ***Assignees*** name, and further I authorize ***Assignees*** to compromise, settle, or resolve said claim or cause of action as they see fit.
To avoid exhaustion of No Fault benefits while ***Assignees*** pursue its right under this assignment, I direct my insurance company to set aside and place in escrow any disputed amounts or reductions until the resolution of such dispute.

I authorize ***Assignees*** to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien and Authorization.

_____ _____

Signature of Claimant Date

Accepted by Authorized Representative of
Drs. Jeffrey MonteLeon and Adriana Quiroga-MonteLeon,
Chiropractic Physicians

LifeForce CHIROPRACTIC

Jeff and Adriana MonteLeon, D.C.
5560 Babcock Street NE, Palm Bay, FL 32907
Phone: 321-409-0209 Fax: 321-409-0208

RECORD REQUEST AUTHORIZATION AND FINANCIAL RESPONSIBILITY AGREEMENT

Patient name: _____ SSN: _____

Birth date: _____ Billing Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

This is to certify that the above named patient authorizes the request of any records pertinent to the health care of same individual from but not inclusive of any insurance carrier, adjustor, attorney, or other health care provider.

This also authorizes this facility to release records, upon receipt of the above named patient's signature, or on an emergency basis, to, but not inclusive of, any insurance carrier, attorney, health care provider, hospital, or immediate family member.

This also certifies that the above named individual agrees to pay in full for all professional services rendered at the time they are performed, unless other arrangements are made in advance of the set appointment. In the case of motor vehicle accidents involving personal injury claims, the patient will be ultimately responsible for deductibles and, or percentages of charges that the insurance company does not cover. The below named guarantor understands a $20.00 returned check fee will be charged along with any appropriate collection or attorney's fee which may accrue upon collection of any outstanding balance.

A photocopy of this assignment shall be considered as effective and valid as the original.

Privacy: The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The u.s. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the *Healt:h Insurance Port:abilit:y and Account:abilit:y Act:* of 1996 ("HIPAN) A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPP A guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party.

I have read and understand the foregoing.

_____	_____	_____
Date	Policyholder/Guarantor	Print Name

LifeForce CHIROPRACTIC

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Office key to Abbreviations

The following represent the individual segments of the spine in sequence from the occiput through the left and right ileum.

0 C1R C1L C2 C3 C4 C5 C6 C7 T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12 L1 L2 L3 L4 L5 S R1 L1

A slash or a circle with a letter indicates the segment adjusted and the technique utilized. A straight line through a segmental group indicates an area that has been checked cleared and was not adjusted.

Techniques:

ACT = Activator Adjustment
D = prone adjustment
P = Pierce adjustment
P/S = Pierce Stillwagon adjustment
HIO = Toggle adjustment
T = Thompson drop adjustment
G = Gonstead adjustment
ANT = anterior adjustment

SL = sacral lock (Thompson) **-** = clear **R** = right **L** = left **Bil** = bilateral **E**= exacerbation **F**= favorable **S**= stabilizing
RX = assessment according to care plan described in the most recent examination **U**= uncertain
NC = no change in current care plan **G**= guarded **IC** = increase care, patient not progressing as expected
DC = decrease care, patient progress exceeding previous expectations **I**= improving **R**= regressing

REST = restrictions upon palpation segmental region
T = tingling
N = numbness
EDEMA = swelling or edema of segmental region
- = clear
C = cervical
T = thoracic
L = lumbar
S = sacrum
MS= muscle spasm
LL = leg length
ADL = activities of daily living
T/T = taut and tender fibers
DF = Derefield leg check
CS = cervical Syndrome
P = pelvis

Complaint:

HA = headache
NP = neck pain
UBP = upper back pain
MB = mid back pain
RNP = Radiating neck pain
LBP = low back pain
SP = sacral pain
TMJ = jaw pain/locked
Ex.P. = extremity pain
RLB = Radiating low back pain

Response: (to the care on each visit)
Excellent **Good**
Fair **Poor**
NC = no change after treatment

Services:

A = Vertebral adjustment 1-2 levels
B = Vertebral adjustment 3-4 levels
C = Vertebral adjustment 5 levels
X = Extremity adjustment
BES = Extended time with a patient / partial examination
OL = Occiput
H = Heat
RE = Re Exam
TMJ = Jaw
CON = Consultation
I = Ice cryo-therapy
TPT = Trigger point therapy
ROF = Report of Findings
IST = Inter-segmental traction
E = Exercise
MAS = Massage

Doctors: **DR1 :** Dr. Adriana Quiroga-MonteLeon **DR2 :** Dr. Jeff MonteLeon

I _____have read and understand the service abbreviations and providing doctor's number.

Patients printed name: _____ Witness printed name: _____

Patients signature:_____ Witness signature: _____