# Table of Contents

## Section 1

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours of Public Service</td>
<td>06</td>
</tr>
<tr>
<td>Health Center Intern Representative Committee</td>
<td>05</td>
</tr>
<tr>
<td>Clinical Education of Doctors of Chiropractic Program</td>
<td>06</td>
</tr>
<tr>
<td>Health Center Graduation Requirements</td>
<td>06</td>
</tr>
<tr>
<td>Requirements to take competency exam:</td>
<td>07</td>
</tr>
<tr>
<td>Intern competency exam (I.C.E.)</td>
<td>10</td>
</tr>
<tr>
<td>Graduation requirements</td>
<td>12</td>
</tr>
<tr>
<td>intern assessments</td>
<td>15</td>
</tr>
<tr>
<td>Eligibility for preceptorship programs</td>
<td>16</td>
</tr>
<tr>
<td>Eligibility for nbce licensing examinations</td>
<td>17</td>
</tr>
<tr>
<td>Patient categories</td>
<td>19</td>
</tr>
<tr>
<td>Clinical competency testing</td>
<td>20</td>
</tr>
<tr>
<td>Intern Hours</td>
<td>24</td>
</tr>
<tr>
<td>Health Center Disciplinary Actions</td>
<td>24</td>
</tr>
<tr>
<td>CODE OF ETHICS AND RESPONSIBILITIES</td>
<td>28</td>
</tr>
<tr>
<td>Satisfactory Clinical Progress (SCP)</td>
<td>31</td>
</tr>
<tr>
<td>Clinical honors recognition of interns</td>
<td>33</td>
</tr>
</tbody>
</table>

## Section 2

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Files</td>
<td>36</td>
</tr>
<tr>
<td>Splitting a File</td>
<td>37</td>
</tr>
<tr>
<td>Patient Care Procedure</td>
<td>38</td>
</tr>
<tr>
<td>The New Patient Process</td>
<td>39</td>
</tr>
<tr>
<td>Re-Activation Patient Process</td>
<td>41</td>
</tr>
<tr>
<td>Transfer Patient Process</td>
<td>42</td>
</tr>
<tr>
<td>The Acute Care Patient and Protocol</td>
<td>42</td>
</tr>
<tr>
<td>Case Management Review (CMR) Process</td>
<td>43</td>
</tr>
<tr>
<td>Report of Findings</td>
<td>45</td>
</tr>
<tr>
<td>Health Center Disciplinary Actions</td>
<td>49</td>
</tr>
</tbody>
</table>

Health Center Manual: Section One
Rev. July 2017
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorized Techniques</td>
<td>49</td>
</tr>
<tr>
<td>Informed Consent</td>
<td>50</td>
</tr>
<tr>
<td>Re-evaluation Exams</td>
<td>52</td>
</tr>
<tr>
<td>CHANGE OF TECHNIQUE</td>
<td>54</td>
</tr>
<tr>
<td>Patient Referrals</td>
<td>55</td>
</tr>
<tr>
<td>Outcome Assessment Tools and Screens (OATS)</td>
<td>56</td>
</tr>
<tr>
<td>Patient Education</td>
<td>58</td>
</tr>
<tr>
<td>Outreach</td>
<td>61</td>
</tr>
<tr>
<td>Report of Findings</td>
<td>63</td>
</tr>
<tr>
<td>Intern Substitution Procedure</td>
<td>64</td>
</tr>
<tr>
<td>Writing in the Patient File</td>
<td>65</td>
</tr>
<tr>
<td>S.O.A.P. Note Format Guidelines</td>
<td>65</td>
</tr>
<tr>
<td>Abbreviations for Health Center Files</td>
<td>67</td>
</tr>
<tr>
<td><strong>SECTION 3</strong></td>
<td>71</td>
</tr>
<tr>
<td>Public Health Recommendations</td>
<td>72</td>
</tr>
<tr>
<td>Crime Prevention</td>
<td>72</td>
</tr>
<tr>
<td>Abuse Reporting</td>
<td>74</td>
</tr>
<tr>
<td>Medicare Guidelines</td>
<td>75</td>
</tr>
<tr>
<td>Community Benefits Program Procedures</td>
<td>76</td>
</tr>
<tr>
<td>HIPAA</td>
<td>77</td>
</tr>
<tr>
<td>Campus Faculty Consultation Guidelines for HIPAA Compliance</td>
<td>78</td>
</tr>
<tr>
<td>Personal Appearance and Dress Code</td>
<td>78</td>
</tr>
<tr>
<td>Preceptorship Program</td>
<td>80</td>
</tr>
<tr>
<td>Recognition of Interns</td>
<td>81</td>
</tr>
<tr>
<td>Standard Process Procedures</td>
<td>83</td>
</tr>
</tbody>
</table>
Section 4 ................................................................. .84
CMR Assessment .................................................. 85
Report of Findings Assessment ................................. .88
Patient Visit Encounter Assessment ............................. .91

Section 5 .................................................................. 162
Imaging Policy .......................................................... 163

Section 6 .................................................................. 171
PATIENT BILL OF RIGHTS ........................................ 172
Products for sale in the Health Center ............................ 174
Institutional Mission

To advance chiropractic through the Doctor of Chiropractic Program (DCP), postgraduate education, philosophical inquiry, research, and scholarly activity in a climate of love and service.

Doctor of Chiropractic Program Mission

Life Chiropractic College West offers a doctor of chiropractic program through a leading edge curriculum and clinical training experience providing graduate chiropractors with the knowledge, skills, philosophies, attitudes, and competencies to serve the health care needs of the public in the 21st century.

The program focuses on the relationship between the structure and function of the human body as coordinated by the nervous system, and the effect of the vertebral subluxation.

The program instills in the chiropractic graduate an appreciation for the innate potential of the human body to heal and adapt to its environment, and the role of the nervous system in the restoration, preservation and enhancement of human health and performance.

The Doctor of Chiropractic program prepares graduates for personal and professional fulfillment in a climate of Loving, Serving and Giving.

Adopted by the Board of Regents on April 1-2, 2011
The Monte H. Greenawalt Health Center

Health Center

HOURS OF PUBLIC SERVICE

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday and Wednesday</td>
<td>12:00 am to 7:30 pm</td>
</tr>
<tr>
<td>Tuesday and Thursday</td>
<td>1:00 pm to 6:30 pm</td>
</tr>
<tr>
<td>Friday</td>
<td>12:00 pm to 5:30 pm</td>
</tr>
<tr>
<td>Saturday</td>
<td>9:00 am to 1:00 pm</td>
</tr>
<tr>
<td>Sunday</td>
<td>closed</td>
</tr>
</tbody>
</table>

The Health Center is closed on specific legal holidays, and as necessary for student testing, or other college functions. The Health Center has free parking, is wheelchair accessible, and no appointments are necessary.

Room numbers for important locations during your Health Center experience:

<table>
<thead>
<tr>
<th>Location</th>
<th>Room Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office of Enrollment (Admissions)</td>
<td>120</td>
</tr>
<tr>
<td>Alumni Affairs</td>
<td>102</td>
</tr>
<tr>
<td>HC Customer Service Manager</td>
<td>107</td>
</tr>
<tr>
<td>Business Office</td>
<td>156</td>
</tr>
<tr>
<td>Cafeteria: Cafe Au Life</td>
<td>108</td>
</tr>
<tr>
<td>Campus Enhancement (Buildings and Grounds)</td>
<td>113</td>
</tr>
<tr>
<td>Continuing/Postgraduate Education</td>
<td>137</td>
</tr>
<tr>
<td>Counseling</td>
<td>105B</td>
</tr>
<tr>
<td>Director of Clinical Competency</td>
<td>248</td>
</tr>
<tr>
<td>Dean of Clinical Education</td>
<td>245</td>
</tr>
<tr>
<td>Department Chairs</td>
<td>131-136</td>
</tr>
<tr>
<td>Dean of the Health Center</td>
<td>244</td>
</tr>
<tr>
<td>Faculty Lounge</td>
<td>104A</td>
</tr>
<tr>
<td>Faculty Offices</td>
<td>146-148, 151</td>
</tr>
<tr>
<td>Financial Aid</td>
<td>119</td>
</tr>
<tr>
<td>HC Faculty Lounge</td>
<td>219</td>
</tr>
<tr>
<td>Health Center Registrar (Mail Room)</td>
<td>110E</td>
</tr>
<tr>
<td>Human Resources</td>
<td>156</td>
</tr>
<tr>
<td>Imaging Lab (Campus)</td>
<td>117H</td>
</tr>
<tr>
<td>Imaging Lab (Health Center)</td>
<td>222-229, 235</td>
</tr>
<tr>
<td>Institutional Advancement</td>
<td>102</td>
</tr>
<tr>
<td>Learning Resource Center (Library)</td>
<td>117</td>
</tr>
<tr>
<td>Inspiration &amp; Business Lounge</td>
<td>220</td>
</tr>
<tr>
<td>Micro/Histology Lab</td>
<td>172</td>
</tr>
<tr>
<td>Pathology/CNS Lab</td>
<td>173</td>
</tr>
<tr>
<td>Preceptorship Program Coordinator</td>
<td>247</td>
</tr>
<tr>
<td>President’s Office</td>
<td>102F</td>
</tr>
<tr>
<td>Public Relations</td>
<td>102</td>
</tr>
<tr>
<td>Registrar (Campus)</td>
<td>122-123</td>
</tr>
<tr>
<td>Student Life</td>
<td>107</td>
</tr>
</tbody>
</table>
HEALTH CENTER INTERN REPRESENTATIVE COMMITTEE

The membership of the Health Center Intern Representative Committee embodies the diverse elements of the college that have direct interest in facilitating the smooth, systematic, and efficient day-to-day operation of the Health Center. Many of the inconveniences that arise during the course of one’s clinical experience come from breakdowns in the lines of communication, and it is in this realm that most of the Health Center Committee’s functions and concerns are centered. These functions include:

■ Suggesting and implementing needed changes in policies or procedures
■ Directing information exchange between the Health Center Administration and interns/students
■ Providing an affirmative environment for the airing of intern/student concerns
■ Holding regular meetings

Students are encouraged to submit suggestions and/or concerns to the committee at any time and may be asked to personally appear before the committee at the discretion of the Dean of the Health Center. Minutes of the Health Center Committee meetings are publicly communicated by the student intern representative as well as on the Intern Cavas Page and may be reviewed upon request to the Dean of the Health Center.

The Health Center Committee is comprised of the following:

■ Deans of the Health Center (will schedule meetings and notify participants)
■ Health Center Customer Service Manager
■ Director of Student Life
■ Executive Assistant of the Health Center

Student intern representatives: One from each outpatient practice group, one from Student Council, one from Student Clinic 1 class, and one from Student Clinic 2 class
CLINICAL EDUCATION OF DOCTORS OF CHIROPRACTIC PROGRAM

Under Supervision and Discretion of the Dean of the Health Center

The Health Center experience is a combination of the following components, including:

1. Classes: Student Clinic 1 and 2, Clinic I, II, III, and IV
2. Tests: Entrance Examination, Mid Proficiency Examination, and Intern Competency Examination (I.C.E.)
3. Hours: 518 patient care contact hours
4. Patient Care: guideline for completion of this requirement is in the Graduation Requirements
5. Outreach: Students are required to complete five (5) community outreach credits. Refer to Quick Reference Guide on HC Intern Canvas page.
6. Participation in a practice Mentoring group

Any interruption in Health Center activity such as results from suspension or voluntary leave that is greater than 10 weeks will require a repeat of the Health Center Entrance Competency Practical Exam to re-enter the Health Center and continue completion of graduation requirements. An interruption in Health Center activity that is 6 months or greater will require a repeat of the Correlative Diagnostic Exam Procedures course, Student Clinic 1, the written Health Center Entrance Exam, and the Health Center Entrance Practical Exam to re-enter the Health Center and continue completion of graduation requirements. Activity that is less than minimum (3 patient care activities per week) for 6 months or more will require a repeat of the Health Center Entrance Practical Exam.

Health Center Advising Program Information & Health Center Course Requirement

1. Syllabi are provided for each course and competency examination and include both specific course requirements and description.
2. School policies regarding tardiness and absences apply to SC1 and SC2 classes. Additionally, mentor group participation is outlined in the Mentor Group Attendance Requirement.
3. If a student fails to complete HC course requirements, it must be retaken in the following term (students will stay with their assigned mentor until graduation). Failure to proceed through the Health Center in the prescribed timely manner will delay anticipated graduation dates.
4. Requirements for clinic course work must be met by Friday of the 1st week of the following quarter in order to change a grade from INC to PASS; otherwise, the grade will be changed to a NO PASS by the beginning of Week 2 with registration and finalized into CAMS by Week 3.
5. A student must be registered in a clinic class in order to engage in any patient related activities in the Health Center.
HEALTH CENTER GRADUATION REQUIREMENTS

The following are Life Chiropractic College West Health Center patient care requirements. These are the minimum requirements to graduate, but we strongly urge you to set your goals higher.

NEW COURSE REQUIREMENTS, COMPETENCY EXAMINATIONS & GRADUATION REQUIREMENTS

QUICK REFERENCE GUIDE

**Student Clinic 1:**
- Pass Entrance Written Exam (75% or better)
- Intern served as a Mock patient for both Entrance Practical/Entrance Practical Remake
- Pass HIPAA Compliance test
- Complete Health Science Reasoning Test (HSRT)
- Hours in HC = 10

**Student Clinic 2:**
- Pass Entrance Practical & X-Ray Exams
- 30 student category patient adjustments
  - **NOTE:** ALL patient encounters to be assessed by HC faculty
- Hours in the HC = 30 (40 total)
- CMRs completed & assessed by HC faculty = 2 student patient
- ROFs as a result of any examination are to be assessed by HC faculty
Attend minimum 3 Clinical Case of the Week with proof of full participation (completion of yellow/multiple choice informatics sheet).
- Completion of the Appraisal Inventory (AI)
- Required attendance HC Recognition Seminar (end of quarter)
- Outpatient care begins once you are assigned to a Practice Group AND have completed 30 student adjustments (Note: Students with less than 10 student adjustments by end of week 5 will meet individually with their new Mentor by end of week 7)

**Clinic 1:**
- Outpatient adjustments = 30 (required by end of Clinic 1 to qualify for Mid Proficiency examination)
- CMRs completed & assessed by HC faculty = 5 total patient (2 must be outpatient)
- ROFs as a result of any examination are to be assessed by HC faculty
- Hours in HC = 120 (160 total)
- Patient encounters assessed by HC faculty. At least 20 outpatient visits assessed by the Mentor (minimum 1 per week).
- Attend minimum 3 (6 total) Clinical Case of the Week with proof of full participation (completion of yellow or green informatics sheet).
- Attendance at required Mentor meetings (LCCW attendance rules apply i.e. >20% = an overcut)

**Clinic 2:**
- Pass Mid Proficiency Examination
- Outpatient adjustments = 70 (required by end of Clinic 2 to qualify for ICE in Clinic 3)
- CMRs completed & assessed by HC faculty = 10 total patient (5 must be outpatient)
- ROFs as a result of any examination are to be assessed by HC faculty
- Hours in HC = 120 (280 total)
- Patient encounters & assessed by HC faculty. At least 20 outpatient visits assessed by the Mentor (minimum 1 per week).
- Attend minimum 3 (9 total) Clinical Case of the Week with proof of full participation (completion of green informatics sheet).
- Attendance at required Mentor meetings (LCCW attendance rules apply i.e. >10% = an overcut)

**Clinic 3:**
- Must pass ICE to pass Clinic 3 & before checking out of HC
- 120 hours in HC (400 total)
- At least 130 outpatient adjustments
- 16 total patient (8 must be outpatient) files though CMR (completed & assessed)
- 6 Assessed CMRs with competent or proficient scoring (defined as 3 or 4 out of 4 on all sections of the CMR rubric)
6 Assessed ROF/Informed Consents with competent or proficient scoring (defined as 3 or 4 out of 4 on all sections of the ROF/Informed Consent rubric)

40 Assessed Patient Encounters with competent or proficient scoring (defined as 3 or 4 out of 4 on all sections of the Patient Visit Encounter rubric)

Attendance at required Mentor meetings (LCCW attendance rules apply i.e. >10% = an overcut)

Clinic 4:

120 hours in HC (518 total)
300 total and 250 outpatient adjustments
20 total patient (16 must be outpatient) files through CMR (completed & assessed)
6 Assessed CMRs with competent or proficient scoring (defined as 3 or 4 out of 4 on all sections of the CMR rubric)
6 Assessed ROF/Informed Consents with competent or proficient scoring (defined as 3 or 4 out of 4 on all sections of the ROF/Informed Consent rubric)
40 Assessed Patient Encounters with competent or proficient scoring (defined as 3 or 4 out of 4 on all sections of the Patient Visit Encounter rubric)
3 Case of the Week (NEW!) with competent or proficient scoring (defined as 3 or 4 out of 4 on all sections of the Case of the Week rubric)
NMS Referral Letter with a grade of 75% or better (DIAG 416-NMS Diagnosis and Management)
Completion of the Appraisal Inventory (AI)
Attendance at required Mentor meetings (LCCW attendance rules apply i.e. >20% = an overcut)

All other graduation requirements must be met in order to pass Clinic 4. Refer to ‘Graduation Requirements’ included in this document listed below.

You must remain ‘Active’ in patient care until such time as all coursework is completed i.e. you may not check out of the HC until your coursework is complete. Refer to the HC Policy & Procedures Manual for the LCCW definition of ‘Active’.

The earliest an intern may check out of the Health Center is week 8 of their final quarter enrolled at LCCW.

Quality Assurance Audits have been appropriately remediated and do not remain outstanding. (This includes HIPPA, ethical or legal issues, accuracy of documentations, diagnosis, billing etc.)

Combination Registration Clinic 3 & 4:
Outpatient adjustments = 130 by week __ of previous quarter to qualify to take Clinic 3 & 4 together
Pass Mid Proficiency examination
Must be in the final quarter of classes

Directed Study (1 Credit):
Clinic 4 completed
Active patient care must be maintained through to Week 8 of the quarter
TABLE OF CONTENTS

REQUIREMENTS TO TAKE LCCW-HC COMPETENCY EXAMINATIONS:

A degree audit will be performed prior to the release of the grades for each of the competency examinations to ensure that each student was eligible to participate. The Dean of the Health Center and/or the Director of Competency reserve the right to withhold the release of a grade.

ENTRANCE EXAM (Two Part Examination—Written & Practical)

Coursework Prerequisites:  

- TECH 116 Palpation I
- TECH 124 Diversified Analysis
- TECH 129 Motion Palpation
- TECH 130 Diversified Technique I
- TECH 216 Biomechanics of the Spine
- TECH 211 Gonstead A
- PATH 315 Bone and Joint Path
- DIAG 239 Spinal Ortho Exam
- TECH 222 Gonstead B
- DIAG 226 Case History
- DIAG 237/737 Neuro Exam Lecture/Lab
- DIAG 236 Exam: Thorax/Abdomen
- DIAG 327 Biomechanics of the Extremities
- ACS 313/813 Radiology I Lecture/Lab
- ACS 322/822 Active Care and Rehab Lecture/Lab
- TECH 238 Diversified Technique II
- ACS 232 Emergency Care
- DIAG 316/816 EENT Lecture/Lab
- DIAG 317 Correlative Diagnostic Procedures
- ACS 335 Radiology II
- ACS 311/811 PT Modalities Lecture/Lab
- TECH 233 Toggle
- TECH 325 Integrated Drop-Table Technique
- HC 310 Student Clinic I
- CPP 318 Patient Education Systems

NOTE:

Classes highlighted may be taken concurrently by petition. Passing the Entrance Practical is a requirement for passing Student Clinic II. A student may be deficient in no more than 20 units total. No more than one technique class may be missing. Student Clinic I & Correlative Diagnostic Procedures must be taken the quarter immediately preceding the Student Clinic II class.

Subject to change due to Curricular changes
The Exam Specifics:

1. Written Exam
   - Serves as the final exam for the Student Clinic 1 course
   - Must pass with 75% or better

2. Practical Exam (including X-Ray Exam)
   - Pass Entrance Written Exam
   - Must be in Student Clinic 2
   - All academic coursework through Junior 1 level completed

MID PROFICIENCY EXAM
(Written Case Presentation & X-Ray Positioning) (return to pg 22)

Coursework Prerequisites:
- DIAG 340  Neurodiagnosis
- ACS 345  Clinical Laboratory Diagnosis A
- ACS 312  Radiographic Positioning
- HC 332  Clinic I
- HC 501  Entrance Exam
- ACS 320  Applied Nutrition
- ACS 346  Clinical Laboratory Diagnosis B
- DIAG 408  Differential Diagnosis A
- TECH 336  Extremity Adjusting
- TECH 339  Extremity Soft Tissue Management

NOTE:
Classes highlighted may be taken concurrently by petition.
Passing Mids is a requirement for passing Clinic II.

The Exam Specifics:

- Must be registered in Clinic 2
- Must have served as a mock patient for the I.C.E. Exam in the same quarter you are taking Mid Proficiency examination (If you are repeating Clinic 2 and/or Mids for any reason, you must be a patient again)
- Minimum 30 outpatient adjustments by the end of Clinic 1
- Management of minimum of 5 patients (2 of which must be outpatient). Patient Management is monitored and overseen by the Mentor in charge of the patient file.
- All academic coursework through Junior 3 level completed

A PASS is defined as:
A minimum score of 75% for ALL sections of the Mid Proficiency Examination.
INTERN COMPETENCY EXAM (I.C.E.)

Coursework Pre-requisites:
- DIAG 420 GI-GU Diagnosis
- DIAG 323 Obstetrics
- ACS 324 Radiology III
- DIAG 412 CV Pulmonary Diagnosis
- DIAG 426 Pediatrics
- DIAG 416 NMS Diagnosis and Management
- DIAG 415 Geriatrics
- DIAG 331 Psychiatry
- ACS 208 Radiology Review
- HC 413 Clinic II
- HC 502 Mid-Proficiency Exam
- Intern must have passed Mid Proficiency examination and Clinic 2 in order to take I.C.E.
- Must pass I.C.E. to pass Clinic 3
- Not allowed to check out of HC or participate in Preceptorship Program unless passed I.C.E.
- Outpatient adjustments = 70
- Management of 10 patients total and 5 outpatient files by the end of Clinic 2 to qualify to take I.C.E. in Clinic 3

GRADUATION REQUIREMENTS

SUMMATIVE ASSESSMENT (Quantitative Requirements)

| Hours in the Health Center 518 Total hours |
|-------------------------------|-----------------|
| Outpatient Adjustments        | 250 250         |
| Student Adjustments           | 50             |
| Adjunctive Therapy/Physiotherapy | 30*          |

NOTE: Intern must bring in 10 Outpatients in total i.e. 10 patients managed through first re-evaluation CMR by the Intern. A minimum of 120 (C1 = 20, C2 = 20, C3 = 40, C4 = 40) outpatient encounters must be assessed. A minimum of 20 outpatient encounters must be assessed per quarter.

50 student patient encounters must be assessed.

* This number varies per state; ensure that you know what is required of you if you are planning on practicing outside of the state of California i.e. this is NOT an LCCW graduation requirement.
### TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Topic</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiology (X-ray)</td>
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<tr>
<td>Case of the Week (X-ray)</td>
<td>15</td>
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<tr>
<td>Rad-Case of the Week (RAD-COW)</td>
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</tr>
<tr>
<td>Clinical Case of the Week (NEW) (CLIN-COW)</td>
<td>3</td>
</tr>
<tr>
<td>Managed Patient Cases</td>
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</tr>
<tr>
<td>Complete Cases TOTAL with the score of 3 or 4/4 on all sections of the rubric</td>
<td></td>
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<tr>
<td>Urinalysis</td>
<td>25</td>
</tr>
<tr>
<td>Complete Blood Count (CBC)</td>
<td>20</td>
</tr>
<tr>
<td>Blood Chemistry</td>
<td>10</td>
</tr>
<tr>
<td>Outreach Opportunities</td>
<td>5</td>
</tr>
<tr>
<td>ALL Competency Examinations = Pass Entrance/Mid Proficiency/I.C.E.</td>
<td></td>
</tr>
</tbody>
</table>

It is important to note that not all requirements for graduation may be met in your Clinic 1-4 classes. If you were a transfer student or changed the pace of your program during either your academic coursework or the Health Center, it is your responsibility to ensure that you understand where you stand in the lead up to graduation.

### NEW FORMATIVE ASSESSMENT (Qualitative Requirements)

<table>
<thead>
<tr>
<th>Category</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMR</td>
<td>12 Assessments (Clinic 3 &amp; 4) with score 3 or 4/4 on all sections of the rubric</td>
</tr>
<tr>
<td>ROF</td>
<td>12 Assessments (Clinic 3 &amp; 4) with score 3 or 4/4 on all sections of the rubric</td>
</tr>
<tr>
<td>Patient Visit Encounters</td>
<td>80 Assessments (Clinic 3 &amp; 4) with score 3 or 4/4 on all sections of the rubric</td>
</tr>
</tbody>
</table>
QUALITATIVE REQUIREMENTS: SAMPLE PAGE

The above quantitative requirements are minimums only. To complete the Health Center requirements, the intern must complete all qualitative requirements as well. These include:

- Assessment of the intern's clinic reasoning abilities as demonstrated through the CMR process and assessment with scores that show progression of understanding throughout the internship.
- Interns are required to demonstrate that they can communicate this information to the patient by completing a formal Report of Findings (ROF) with the patient following each examination. The intern will be assessed during the ROF by his/her mentor at least twice in each quarter enrolled in the Health Center.
- Assessment of the intern's clinical skills as demonstrated through the regular and continued visit assessments with scores that show progression and minimal understanding throughout the internship.
- Successful passing of all the Health Center Competency exams, including: Written Health Center Entrance Exam, Practical Health Center Entrance Examination, Mid Proficiency Examination, Intern Competency Exam (I.C.E., also known as the Exit exam).

By this process, meta-competencies as described by the CCE will be assessed. A copy of the meta-competencies as described by the CCE are provided in the administrative department of the Health Center and are also available online through the CCE website. Interns are required to show competence in all of these areas. Students who complete the quantitative requirements but fail to meet the qualitative requirements as outlined above will not graduate until all requirements are completed. If by the end of the 4th quarter in the outpatient clinic, qualitative requirements (including all competency exams) are not completed successfully, the intern will be required to register for an additional quarter and remain in practice under the direction and mentorship of the assigned mentor until all requirements have been met. No student who has not met all of the requirements will be allowed to graduate or to participate in a Preceptorship until all requirements are successfully completed.
COURTESY PATIENTS INCLUDE THE FOLLOWING SUB-CATEGORIES:

Student Courtesy (Files beginning with 7 and count as student credits)
- Student enrolled at LCCW
- Parents, spouses, and dependent children 17 or younger of all LCCW students are considered Student Family
- All LCCW students are allowed to designate two (2) courtesy patients. The courtesy patients cannot be reassigned to outpatient status until the student graduates.
- LCCW Alumni up to 2 years from their graduation date
- All courtesy patients pay for lab work and supplies such as cervical collars, heel lifts, etc.

Outpatient Courtesy
- Faculty and staff of LCCW and their immediate families (spouse, partners, and dependent children age 17 or younger)
- Community Benefits patients
- LCCW Alumni after 2 years from their graduation date.
- All courtesy patients pay for lab work and supplies such as cervical collars, heel lifts, etc.
- LCCW Rugby players (but not their family members)

Outpatient Category Patients (General Public)

INTERN ASSESSMENTS

CMR Assessment

The CMR assessment will be completed by the CMR faculty during all student patient CMR’s as well as all new patient CMRs and on any intern who is not progressing as expected. The CMR assessment serves to identify the strengths and weaknesses of the intern with regard to his/her ability to formulate an appropriate clinical impression and care plan. All CMR assessments will be maintained as part of the intern’s mentor records and will be used to assess the interns’ progress.

REPORT OF FINDINGS ASSESSMENT

All Report of Findings are assessed by a Health Center Faculty. The Informed Consent is part of the Report of Findings (ROF).

Patient Visit Assessment

Each intern-patient care contact is considered an important competency element in the education of the intern. The observer, therefore, may document or otherwise report his/her findings as part of the competency record of the intern. All visit assessment forms will be maintained as part of the intern’s mentor records and will be used to assess progression.
Grading Criteria for Patient Visit Evaluations

The following criteria are to be used to grade patient visit evaluations. These criteria will be used for all interns and for all observed patient visits, except for OTOs. Please use the additional comment section of the evaluation form if necessary.

Professional Component:

Interns will receive a score between 1-5 for professionalism. Faculty will take into account the following components and will give one average score.

Records Component

Interns will receive a score between 1-5 for records. Faculty will take into account the following components and will give one average score.

Adjusting Skills Component:

Interns will receive a score between 1-5 for adjustment skills. The intern will be given separate grades for each region of the spine adjusted that visit. Faculty will take into account the following components and will give an average score for each region.

ELIGIBILITY FOR PRECEPTORSHIP PROGRAMS

UNDERGRADUATE PRECEPTORSHIP

- PASSED ICE (Week 1 of Clinic 3)
- Achieved four quarters of Outpatient care (all patient care requirements must be met (except hours). Note: Hours in the preceptor office can count towards graduation requirements.
- All competency exams passed.
- Earliest possible date of departure is Week 8 of Clinic 3. This requirement is set by the CCE.
- Intern MAY continue to see patients in the Health Center while participating in the Undergraduate Preceptorship Program.
- NOTE: This is a viable option for students that have met their HC requirements but have outstanding coursework. This would allow you to check out of the HC and participate in a preceptorship while attending your classes during the same quarter.

POSTGRADUATE PRECEPTORSHIP

- Can begin as early as Week 8 of the graduation quarter providing the graduate have met ALL college requirements for graduation and has checked out of the Health Center with the Health Center Registrar.
ELIGIBILITY FOR NBCE LICENSING EXAMINATIONS

NBCE exam requirements.

**Part I** – Must have completed all Basic Science classes through Sophomore C/2 at the time of the exam. The student must have passed or be concurrently enrolled in Science Review. The student can be missing one Basic Science class.

**PT** – Must have passed Active Care and Rehab Lecture & Lab and PT Modalities Lecture & Lab. Students may submit the application while concurrently enrolled, but final passing grades must be posted in order to receive Registrar approval.

**Part II** – At the time of the application, the student must be completing all Junior 3 courses and be concurrently enrolled in Senior 1 in the quarter of the exam. The student can be missing 1 course through Junior 3. At the time of submitting the application, students need to be enrolled in at least Clinic 1.

**Part III** – Student must have 5 total CMRs (3 outpatient CMRs) and at least 120 Clinic hours. The student must be within 9 months of graduation.

**Part IV** – Student must have 8 total CMRs (4 outpatient CMRs) and at least 200 Clinic hours. The student must be within 6 months of graduation.

**Students can only apply for 2 tests in a given offering.**
Ex: PT and Part II or Part II and Part III.

NOTE: In the case of ‘Incomplete’ grades or grade disputes, students may have to file after the preferred application deadline. In this case, the student may be approved for the next NBCE offering.

**YOUR CONTACTS & THEIR ROLE:**

**Dr. Tamara MacIntyre** – Interim, Dean of Health Center (incl. new graduation requirements)

**VACANT** – Executive Assistant to the Dean of Clinics, Outreach Coordinator

**Dr. Bruce Chester** – Director, Clinical Competency Examination & Clinic Standards Committee (CSC)

**Jennifer Jerdonek** – Clinical Education Coordinator & Coordinator of Competency examinations

**Khanh Nguyen** – Quality Assurance Program Analyst (Qualtrics assessment Data)

**Dr. Michelle Massa** – Compliance Officer

**Dr. Jon Nichols** – Imaging Director

**Michelle Montoya** – College Registrar

**Maria Lopez** – College Registrar Assistant

**Judy Lum** – Health Center Registrar (Calculation of the ‘numbers’ met towards graduation ONLY)
Dr. Scott Donaldson – Vice President of Academic Affairs


Jackie Biron – Director of Student Life, Coordinator of the Graduation Ceremony, gowns etc.

Definition of Roles

Health Center Faculty Doctors fulfill several roles for interns in the Health Center, and their purpose is to assist interns in the practical clinical applications of the skills they have learned to date as they transition from students of the science, philosophy and art of chiropractic to a practitioner preparing to join the profession upon graduation.

Mentor Doctors – These doctors lead a group of interns in smaller practice groups in order to help develop their case management and adjusting skills. They are available to discuss and advise on patient cases, advise on marketing opportunities, to review patient files, and as a reference for college policies and procedures. When an intern is assigned to a Mentor Group or practice, he/she is required to attend weekly practice meetings, and the Mentor is his/her point person for any issues relating to his/her time in the Health Center.

A Student Clinic 2 intern is assigned to a practice group and Mentor at the quarterly draft at which interns make their preferences known, and the Mentor doctors make their selections based on many factors relative to the needs of the practice. Interns are practicing under the license of their Mentor doctor, and is responsible for the patient care by his/her interns.

Health Center Faculty Doctors – These doctors serve additional roles within the Health Center. Interns have the opportunity to learn from these doctors in the Radiology department where they will learn how to take radiological images as well as to effectively communicate with patients, increasing the patient’s confidence in their intern. Interns participate in guiding their patients through the x-ray process in order to gain the appropriate images necessary for their chiropractic care.

Additionally, these doctors conduct Case Management Reviews (CMRs) where the interns’ diagnosis, management plan and prognosis and goals of care for their patients are reviewed, discussed, approved and assessed. Over time, this helps the interns to create thoughtful, intelligent and detailed management plans for their patients.

Finally, these doctors also oversee direct patient care in the Student & Outpatient Health Center as interns deliver patient Report of Findings, review the informed consent form, and deliver chiropractic adjustments and related care. Whether in the Student Health Center or in the Outpatient Health Center, patient interactions are routinely observed and assessed by Health Center faculty who are available to assist with care as needed, make appropriate recommendations and review interns’ patient records for accuracy and completion.
PATIENT CATEGORIES

This policy applies to students entering student clinic 2 in the summer 2017 quarter and beyond.

Patient Categories

Courtesy patients include the following sub-categories:

Student Courtesy: (Files beginning with 7 and count as student credits)

- Students enrolled at LCCW
- LCCW Student Family if the Intern is caring for their own family (spouse, partners, & dependent children aged 17 or younger) *
- All LCCW students are allowed to designate two (2) student category courtesy patients. The courtesy patient cannot be reassigned to outpatient status until the student graduates.
- LCCW Alumni up to 2 years from their graduation date

All Student Courtesy patients pay for lab work and supplies such as cervical collars, heel lifts, Foot Levelers etc.

Outpatient Courtesy:

- Faculty and staff of LCCW and their immediate families (spouse, partners, & dependent children aged 17 or younger).
- LCCW Student Family if the Intern is caring for another LCCW Student’s Family (spouse & children aged 17 or younger)*
- Community Benefits patients
- LCCW Alumni after 2 years from their graduation date
- LCCW Athletes including community players (but not their family members)
- LCCW Café Employees

All Outpatient Courtesy patients pay for lab work and supplies such as cervical collars, heel lifts, Foot Levelers etc.

*NOTE THE FOLLOWING CLARIFIERS/CLARIFICATIONS:

- Must designate category during New Patient file activation.
- No change in patient category until student graduates.
- LCCW family members can only transfer to their family member intern as transfer patients in SC-2 after obtaining a pass on the Clinic Entrance Practical exam and ONLY while they are registered in their SC-2 quarter.
  - i.e. If a quarter 2 student has their family being seen in the Health Center, that family can transfer to the student ONLY when they are in SC-2 and after they have passed the Clinic Entrance Practical exam.
- Patient has option to change Interns but not category
- No more than 2 Outpatient courtesy patient files are to be active at any one time with a maximum of 4 total towards graduation requirements.
Effective for SC-2 students SUMMER 2017

- Any file category considerations are to be filtered through the Mentors for review.
  - This includes retroactively changing LCCW Student Family categorization

**FORMER DEFINITIONS (SC-1 WINTER2017 or before):**

**Patient Categories**

Courtesy patients include the following sub-categories:

**Student Courtesy (Files beginning with 7 and count as student credits)**

- Students enrolled at LCCW
- Parents, spouses, and dependent children 17 or younger of all LCCW students are considered Student Family
- All LCCW students are allowed to designate two (2) courtesy patients. The courtesy patient cannot be reassigned to outpatient status until the student graduates.
- LCCW Alumni up to 2 years from their graduation date
- All courtesy patients pay for lab work and supplies such as cervical collars, heel lifts, etc.

**Outpatient Courtesy**

- Faculty and staff of LCCW and their immediate families (spouse, partners, and dependent children aged 17 or younger).
- Community Benefits patients
- LCCW Alumni after 2 years from their graduation date
- All courtesy patients pay for lab work and supplies such as cervical collars, heel lifts, etc.
- LCCW Rugby players (but not their family members)

**Adjunctive Therapy (Physiotherapy):**

The California Board of Chiropractic Examiners requires the application of 30 physiotherapy modalities on the intern's own patients for licensure, which includes any of the physiotherapy modalities taught at LCCW. This is State requirement, not just an LCCW graduation requirement. It is strongly advised that students personally obtain information on the educational and licensure requirements of the states or regions in which they may wish to practice. The Learning Resource Center at LCCW maintains a file of individual state requirements for consultation.

**CLINICAL COMPETENCY TESTING**

1. Under normal circumstances, the Practical Entrance Exam and the exit Intern Competency Exam (I.C.E.) are administered during the first week of the quarter. The Mid Proficiency exam is administered during the 6th week of the quarter. The students are provided information about each examination in advance of the testing date(s).
2. All clinical tests must be taken in sequence during the scheduled dates of examination in each quarter, and may not be taken concurrently with one another.
3. Each test is comprised of one or more component subject areas including: diagnostic skills, technique, x-ray, physiotherapy and some patient education. Achievement of a score of 75% or more is required to pass any test component. Under normal circumstances, grades will be reported to the student and remake examinations are then scheduled as needed.

4. Appeals following test failure are not possible until after the remake examination has been taken.

5. In a remake situation, whenever possible, the examiner who tested the student in the initial examination will not test the student again.

6. College policy for fees applies for a clinical remake examination. A remake is defined as 1 or more components of the original exam.

7. Failure of a clinical examination (the test and its remake) two times will result in a summative evaluation and academic notice.

8. If the student receives a “No Pass” then the entire examination must be retaken the following quarter.

9. Entrance Examination: Interns can see their reciprocal as assigned in the Correlative Diagnostic Exam Procedure class. Once the Written examination is passed, the intern can also see other enrolled students. Upon passing the Practical Entrance exam, the intern can see any patient in the student category (including student family and student courtesy patients).

10. Mid Proficiency Examination: Passing the Mid Proficiency exam is required to pass Clinic II and to qualify for I.C.E.

11. Interns must pass I.C.E. in order to pass Clinic III

12. Intern Competency Exam (I.C.E.): the student must pass all components of I.C.E. as a requirement for graduation

**Clinic Examination Course Requirements**

Entrance Examination 501: 1 unit

Test Goal: The entering intern should display entry level competency in eliciting information from the history, physical examination, x-ray studies, and spinal exam stations. They must also be able to demonstrate basic psychomotor skills in the physical examination, physical therapy modalities, and in the four technique stations. Candidates should show the ability to recognize when presenting conditions fall outside of normal and interpret those findings to arrive at working conclusions. They must also show the professionalism to be able to perform the above in a stressful environment.

The Entrance Examination consists of:

1. Written Exam
2. Practical Exam

Includes a 25 station multiple choice X-ray reading exam

The Written exam is 100 questions in a multiple-choice format. The candidate is also responsible for X-ray markings taught in core technique classes and for CMR required lines of mensuration as shown in the Health Center Manual. The candidate is not required to bring x-ray marking tools. Questions will include material on technique, diagnosis, x-ray, physiotherapy and the Health Center Policies and Procedures. This examination also serves as the final examination for the Student Clinic 1 course.
If a student fails the Written Entrance exam and its remake, she/he will be required to retake Student Clinic 1 class and retake the examination the following quarter.

Passing of the Written exam is required for the intern to proceed to the additional portions of the exam.

The Practical portion of the exam is designed to test the candidate’s ability to think critically, verbalize, and demonstrate their knowledge in technique, diagnosis and patient education (see Entrance Exam material distributed in Student Clinic 1 class). The practical portion of the exam is given in week one of the Student Clinic 2 quarter.

- The practical exam includes a 25 station multiple choice x-ray reading exam.
- The multiple-choice x-ray reading exam includes normal skeletal anatomy and variants, congenital anomalies, trauma, and arthritis.
- All academic course work, through Junior 1 level, is required to take the Entrance Practical. See page 10.
- If a student fails the Practical Entrance exam and its remake, he/she will be required to retake the Student Clinic 2 class and repeat the Practical examination the following quarter.
- Students must be enrolled in a clinic class in order to provide any patient care.

Any interruption in Health Center activity such as results from suspension or voluntary leave that is greater than 10 weeks will require a repeat of the Health Center Entrance Practical Exam to re-enter the Health Center and continue completion of graduation requirements. An interruption in Health Center activity that is 6 months or greater will require a repeat of the Correlative Diagnostic Exam Procedures course, Student Clinic 1, the written Health Center Entrance Exam, and the Health Center Entrance Practical Exam to re-enter the Health Center and continue completion of graduation requirements. Activity that is less than minimum (3 patient care activities per week) for 6 months or more will require a repeat of the Health Center Entrance Practical Exam.

**Mid Proficiency Examinations: 502: 1 unit**

Test Goal: The intern must demonstrate the ability to interpret, synthesize and apply appropriate critical thinking skills in the development of a management plan for a given case. This must include: a working diagnosis and differentials, a realistic care plan including any additional tests, lab and x-ray assessment, appropriate referrals and a functional and structural prognosis. The Mid Proficiency exam is given to determine clinical progress and identify areas of weakness or deficiency.

The following is required to take the Mid Proficiency Exam:

1. All academic course work through the Junior 3 level. (See page 11)
2. The student must participate as a mock patient for I.C.E. in Clinic 2 and each subsequent quarter until the Mid Proficiency Exam is passed
3. 30 outpatient adjustments by the end of Clinic 1
4. The student must have managed at least 5 files, 2 of which MUST be outpatient
5. The test is normally taken during the 6th week of the Clinic 2 quarter and an intern is considered to be progressing normally if they qualify to take it then. The test may be taken during the Clinic 1 quarter if the intern has otherwise qualified, including coursework.
Mid Proficiency Exams consist of:

1. Written Case Presentation
2. X-ray positioning

For the Case Presentation the intern is given a simulated patient file. The intern is expected to write a presentation similar to a case summary narrative. The presentation will include a complete diagnosis, 2 differential diagnoses, a plan of care, prognosis, and discussion of x-ray and lab findings.

The intern is required to know the correct x-ray positioning for a Basic 7 series and will be expected to demonstrate and explain this information.

Should an intern fail to successfully pass the Mid Proficiency exam and remake, he/she will receive a “No Pass” for the exam and will have to retake those parts failed the following quarter. The student will also receive a No Pass for Clinic II.

Intern Competency Examination (I.C.E.)
also known as Exit Examination: 503-01: 1 unit

Test Goal: The candidate must display exit level competency on a multi-station simulated patient exam consisting of comprehensive analysis, case management, co-management, or referral, if necessary, and demonstrate patient examination and adjusting skills. The exam will include the following:

1. Diagnosis and Case Management
2. Chiropractic Technique
3. X-ray interpretation

The following is required to take the I.C.E. test:

1. Intern must have passed the Mid Proficiency Exam in a previous quarter
2. Intern must have completed 70 outpatient adjustments and have managed a total of 10 patient files (at least 5 of which must be outpatient files) by the end of Clinic II
3. See the college website for specific course requirements: (See page 12)
4. Should an intern fail to successfully pass the I.C.E. exam and remake, he/she will receive a “No Pass” for the exam and will have to retake those parts failed the following quarter. The student will also receive a No Pass for Clinic III.

Interns are not allowed to check out of the Health Center or participate in the Preceptorship Program unless they have passed I.C.E.
INTERN HOURS

California law for chiropractic students requires 518 clinical hours. Required Health Center hours are recorded by means of a check in/out procedure.

- At the Records Room, you must check in and out, in clinic attire.
- If you are checked in, you must be on the Health Center premises and be available for patient care.
- Failure to check out prior to leaving the Health Center will result in zero hours for the day
- Interns may not be clocked in when they are supposed to be in class or when performing work study job duties.

HEALTH CENTER DISCIPLINARY ACTIONS

When the College determines the need to address behavioral or performance matters within its own structure, the policies and procedures in the Disciplinary Policies and Procedures Manual will be followed.

I. ADMINISTRATIVE INTERVENTION

When circumstances exist in which the safety and/or welfare of the college community is jeopardized by the action(s) of one or more students, the College retains the right to intervene, taking immediate administrative action.

II. CONFLICT RESOLUTION

The College attempts to resolve complaints concerning violations of policy or conduct through the Health Center Deans/Conflict Resolution Officer or Life West (CRO). An Incident Report or Formal Student Grievance Form may or may not be filed in these matters. The CRO will meet with the parties involved in a timely manner to discuss the details of the dispute. The CRO will mediate with the goal of resolving the conflict between the parties. If a resolution is reached by the parties involved, no further action will be required. The resolution may include sanctions.

Examples of Situations the Conflict Resolution Officer Could Mediate:

- Conduct Issues (student/student, faculty/student)
- Room-mate Issues
- Unprofessional & Inappropriate Behavior
- On Campus Dispute

<table>
<thead>
<tr>
<th>Nature of infraction/offense</th>
<th>Possible Administrative action to be taken</th>
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<tbody>
<tr>
<td>Continued care past re-eval CMR and date</td>
<td>Loss of related patient care credits + minimum 1 quarter HC suspension to expulsion</td>
</tr>
<tr>
<td>Unobserved/unauthorized patient care – anything not approved in the CMR (This includes abiding by approved frequency of care)</td>
<td>Loss of related patient care credits + minimum 1 quarter HC suspension to expulsion</td>
</tr>
<tr>
<td>CMR not signed and accepted by patient. Evidenced by signature in CMR action page.</td>
<td>Loss of credit, includes CMR assessment credit</td>
</tr>
<tr>
<td>Patient care without faculty approval – anything not approved in the CMR</td>
<td>Loss of related patient care credits + minimum 1 quarter HC suspension to expulsion</td>
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<tr>
<td>Failure to report Work Comp or PI case</td>
<td>Loss of related patient care credits + minimum 1 quarter HC suspension to expulsion</td>
</tr>
<tr>
<td>Fraudulent signatures</td>
<td>HC expulsion</td>
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<tr>
<td>Falsified records – including completion of any part of the record without the patient present</td>
<td>Loss of related patient care credits + minimum 1 quarter HC suspension to expulsion</td>
</tr>
<tr>
<td>Patient Abandonment – including failure to assign vacation relief or discontinued care without notification to patient and Practice Mentor</td>
<td>Loss of related patient care credits + minimum 1 quarter HC suspension to expulsion</td>
</tr>
<tr>
<td>Unprofessional behavior including argumentative behavior, verbal abuse to staff or faculty, or paying for patients’ Health Center treatment</td>
<td>Loss of related patient care credits + minimum 1 quarter HC suspension to expulsion</td>
</tr>
<tr>
<td>Failure to keep patient appointment</td>
<td>Loss of related patient care credits</td>
</tr>
<tr>
<td>Student patient seen as an outpatient</td>
<td>Loss of related patient care credits</td>
</tr>
<tr>
<td>Failure to complete SOAP properly – including incomplete post note</td>
<td>Loss of related patient care credits</td>
</tr>
<tr>
<td>Failure to complete missing information in patient file as indicated by Blue Dot and Faculty Notes</td>
<td>Loss of patient care credits provided while blue dot remains unresolved related to blue dot</td>
</tr>
<tr>
<td>No Show for x-ray appointment</td>
<td>Loss of 5 outpatient adjusting credits and related x-ray credits</td>
</tr>
<tr>
<td>No Show for CMR appointment</td>
<td>Loss of 5 student/outpatient adjusting credits (SC1 and SC2 - student; C1-C4 - outpatient)</td>
</tr>
<tr>
<td>*Plagiarism on any HC assignment</td>
<td>Loss of credit for the assignment + minimum 1 quarter HC suspension to expulsion</td>
</tr>
<tr>
<td>*Cheating on Competency exam</td>
<td>Loss of credit for the assignment + minimum 1 quarter HC suspension to expulsion</td>
</tr>
</tbody>
</table>

**HIPAA Violation - See Section 3**

1st offense: → 3 page paper
2nd offense: → Two week suspension
3rd offense: → Suspension up to expulsion

**Dress Code Violation - See Section 3**

1st infraction: → The intern will be sent home to change and will lose two outpatient adjusting credits
2nd infraction: → The intern will be sent home to change and will lose five outpatient adjusting credits
3rd infraction: → The intern will be sent home and will be immediately suspended from the Health Center for one week.
III. ADMINISTRATIVE RESOLUTION

When a complaint or alleged violation of college policy occurs that involves more serious violations of college policy, an Incident Report, Notice of Concern (NOC) or Formal Student Grievance Form should be filed with the Health Center Deans/Conflict Resolution Officer of the College. The College will pursue issues of this nature whether a formal incident report has been filed or not.

Other Examples of Violations: (Not listed above)

- Ethical Violations (including cheating on exams & plagiarism)
- Falsifying Documents (including signatures on documents)
- Safety Issues (including practicing Chiropractic without a License)
- Unobserved Adjusting
- Using Unapproved Techniques in the Technique Labs or Health Center
- Bringing a firearm to campus
- Being under the influence of drugs or alcohol while on campus or in the Health Center.

Upon receipt, either Dean of the Health Center will review the completed Incident Report, Notice of Concern or formal Student Grievance Form and route it to the appropriate College Administrator for investigation and administration. The administrator will serve as the College Disciplinary Officer in the matter. They will schedule and hold a conference with the student charged and obtain his or her response to the alleged misconduct, except in instances where the student charged declines to cooperate, in which case the conference requirement is waived. The Disciplinary Officer may opt to resolve the complaint with or without sanctions.

If the alleged student(s) admits culpability in the matter and a customary and usual Sanction (from the published list) is given based on the facts and seriousness of the issue there is no appeal available to the student. The disposition of the matter will be provided to the accused in writing and be signed by the student and the Disciplinary Officer assigned to the matter.

If the student admits a violation of misconduct and the student can demonstrate that the sanction imposed is not the usual or minimum sanction given similar circumstances, the student charged may request a hearing on the sanction only. If the alleged student(s) does not admit culpability they are entitled to meet with the Chair of the Student Judicial Committee and request a Judicial Hearing to review all facts of the Incident Report and during that Hearing the misconduct will be examined. Sanctions may or may not be given as a result of the evidence presented at the Judicial Hearing.

Neither legal representation for the accused student or the College, nor tape or electronic recording will be permitted during the Administrative Resolution process. (Pages 4-5 Disciplinary Policies & Procedures)
On occasion a Health Center Faculty may see the necessity to engage a student intern in a conversation to address an issue and provide a student with a learning opportunity or a written warning. These conversations can be documented using the following form to outline the issue raised, the exact specifics of the situation and the action steps required on behalf of the faculty and the students to address the issue raised. This form will be included in the Mentor/Practice Advisor Intern file and will serve as record of conversations had and issues raised with a student during their internship. These issues may relate to Satisfactory Clinical Progress (SCP) or a potential Disciplinary matter. Refer to page _____ for additional clarification.

**Sanctions within the LifeWest Health Center Include:**

**Health Center Suspension**

Separation of the student Intern from the Health Center for a definite period of time, determined by the Dean of the Health Center.

**Health Center Expulsion**

The termination of student status for an indefinite period of time. Permission of the President of the College is required for readmission. The official transcript of the student is noted “DISCIPLINARY EXPULSION EFFECTIVE ____________.” This notation will remain permanently on a student’s academic transcript.

**Alcohol and Drugs**

Any intern suspected of being under the influence of alcohol or recreational or mind-altering or psychomotor altering drugs will be removed from the Health Center immediately and reported to the Dean of the Health Center for disciplinary action. The intern will be relieved of all Health Center duties and functions until all appropriate actions have been taken.

**CODE OF ETHICS AND RESPONSIBILITIES**

The code of ethics for Life Chiropractic College West Health Center embraces the responsibilities and obligations of the interns and faculty.

**Responsibilities of the Intern to the College:**

- Each intern must follow all Health Center policies and procedures.
- Each intern is responsible for maintaining a professional attitude and behavior within and outside the college and Health Center.
- Each intern, when in doubt, must refer discussion of Health Center fees to the Health Center Customer Service Manager. See Health Center Information chain chart for proper question/answer authority.
- Each intern is responsible for his/her own work with patient files and all assignments related to the Health Center Advising program or classes (see also the LCCW Catalog and Student Handbook).
Responsibilities of the Intern to the Patient:

- The ultimate purpose of your efforts should be to affect the greatest health benefit for your patient. Patient neglect in any form, therefore, will not be tolerated.
- You should bear in mind the great responsibility your profession involves and should conduct yourself as to acquire the confidence and respect of your patients.
- You should attend to a patient as often, and only as often, as is necessary to ensure continued, favorable progress.
- The doctor/patient relationship gives you the opportunity to exercise powerful influence with the patient. This influence should always be used in a positive manner.
- You should develop an awareness of your responsibility to refer your patient appropriately when satisfactory results are not being achieved or when diagnosis indicates that other care is needed.
- Each intern is responsible for the accuracy and completeness of his/her patient records.
- You shall not discriminate on the basis of race, color, creed, gender, age, or ethnic background in the selection and/or care of patients.

Responsibilities of the Intern to the Profession:

- Professional conduct should be a priority of the intern. It reflects on the nature of the institution from which he/she will graduate, the profession at large, and the intern him/herself.
- The intern should attempt to contribute to the enrichment of scientific knowledge whenever possible.
- The intern is encouraged to associate him/herself professionally, in state and national chiropractic organizations, in order to honor and dignify the chiropractic profession and to expand its sphere of influence.
- Any conversation with a patient who is under the care of another practitioner should observe the strictest caution and reserve. No course of conduct should be pursued that might directly tend to diminish the trust in any other practitioner.
- When attending a patient who is regularly under the care of another intern, the care plan as approved at CMR by the regularly attending intern must be followed. Any additional recommendations or care can only come from an LCCW Health Center faculty.
- It is your duty as a good citizen to be vigilant for the welfare of the community and to do your part wherever possible. You should be ready to give counsel to the public on matters pertaining to your profession, such as structural biomechanics and ergonomics, general hygiene, and sound health and sanitation practices that help control and prevent epidemics.
- Avoid unguarded statements about chiropractic successes, which tend to produce misconceptions in the minds of the community.
- Always be prepared with proper, complete patient records to aid representatives from the LCCW Health Center in the event they are called upon to testify in legal proceedings or matters pertaining to the profession.
Rights and Responsibilities of the Students and Faculty

Students have the right:
- To know how their grade will be determined and that accurate records of progress will be maintained.
- To have clearly stated expectations, objectives, and requirements
- To have the opportunity and resources provided to meet objectives
- To have faculty accessible according to college guidelines
- To have knowledgeable faculty
- To be treated as individuals
- To be evaluated objectively
- To confidentiality
- To have input into the decision-making process
- To expect the Health Center faculty to demonstrate professionalism in all respects.

Students are responsible:
- To prepare for class and clinical experiences
- To avail themselves of and pursue experiences provided
- To meet curriculum requirements
- To do self-evaluation and set learning goals
- To be self-directed
- To be respectful and courteous
- To treat others as individuals
- To respect privacy and confidentiality
- To demonstrate professionalism in all respects
- To respect the faculty right to due process
- To evaluate faculty objectively
- To be honest, fair, and responsible

Health Center faculty have the right:
- To expect interns to be prepared for class and clinical experiences
- To expect interns to avail themselves of and to pursue learning experiences provided
- To establish curriculum requirements
- To expect interns to do continual, ongoing self-evaluation and set learning goals
- To expect interns to be self-directed and disciplined
- To be respected and treated courteously
- To be treated as individuals
- To privacy and confidentiality
- To expect interns to demonstrate professionalism in all respects
To due process
To an objective evaluation
To expect honesty, fairness, and responsibility from interns

**Health Center faculty are responsible:**
- To provide a procedure for due process
- To provide information in regard to progress and how grades are determined
- To identify expectations, objectives, and requirements clearly
- To provide opportunities and resources to meet objectives
- To maintain accessibility to students
- To be competent practitioners
- To treat interns as individuals
- To evaluate interns objectively
- To maintain confidentiality
- To provide a forum for intern input
- To always demonstrate professionalism in attitude and behavior

**SATISFACTORY CLINICAL PROGRESS (SCP)**

Federal regulations require that Life Chiropractic College West establish, publish and apply reasonable standards for measuring student’s Satisfactory Academic Progress (SAP) in their educational program. The qualitative and quantitative standards used to monitor academic progress must be cumulative and must include all periods of the student’s enrollment. This policy will be enforced at the end of each term. In the Health Center, this is referred to as “Satisfactory Clinical Progress (SCP)”.

"The following definitions apply to terms used in this policy.

**Clinical Plan**: A plan, which if followed, should improve an intern’s ability to meet Life West’s Satisfactory Clinical Progress (SCP) standards by a specific point in time. Interns who have been placed on a clinical plan must meet the modified standards of clinical progress outlined in the plan or he/she may be dismissed from the Health Center.

**Appeal**: Appeal is a process by which an intern who is not meeting the satisfactory clinical progress standards may submit a petition, outlining the circumstances for his/her clinical performance and explain what has changed that would allow him/her to regain good clinical standing to the Clinical Standards Committee for reconsideration to remain in the Health Center program. After reviewing the petition, the Clinic Standards Committee may ask for more information and may request that the intern review their appeal in person with the committee. The decision of the committee is final.

If the first appeal is approved, subsequent appeals will only be considered if an intern’s reason for his/her clinical performance has changed from an earlier appeal. **An intern may only appeal twice under this policy.**
A ‘Record of Counsel’: Record of Counsel may be executed by any Health Center Faculty or Administrator and provided to either the Dean of Clinics or Dean of Clinical Education for review. The Dean most appropriate for the nature of the conversation will meet with the faculty prior to engaging in a conversation with a student regarding an issue of concern relating to SCP or a potential for behavior in need of correction not outlined in the itemized list of disciplinary infractions on p.22. These issues will be addressed in both verbal and written form. They will serve as record on the Mentor/Practice Advisor student Intern file.

Completion Rate: Enrollment in the program cannot continue for an indefinite period of time. Interns are expected to complete their degree in the 14 (Standard) or 12 (Accelerated) terms scheduled in the curriculum. Some interns, however, require extra time to complete the degree. Time of completion for the Health Center requirements is four quarters.

Consequences of not meeting Satisfactory Clinic Progress (SCP): Life West interns are expected to perform at the highest academic and clinical levels. Those interns who do not meet the standards of Satisfactory Clinical Progress are subject to the following consequences:

Clinical Concern: A student may be placed on Clinical Concern whenever a clinical event occurs, which, if not corrected, may lead a student to fall below the minimum standards of SCP. A student on Clinical Concern is in good academic standing, and retains all rights, privileges, and financial aid eligibility of a regular student. Some of the events which may prompt a Clinical Concern are:
- Failure of any Clinical Competency exam more than two times
- Three or more Notices of Concern in one quarter
- Failure of any Clinic class two times
- Time of completion six quarters or more of Outpatient Care (C1-C4)

Interns, whose clinical performance reflects any of the above activity, should be aware that their future in the clinic and date of graduation may be impacted.

Clinic Warning: Clinic warning is assigned by the Dean of the Health Center to an intern who fails to make SCP and must meet the minimum standards by the end of the next term of enrollment.

Clinic Probation: Interns who fail to make Satisfactory Clinic Progress within one quarter immediately following a term of clinic warning will be required to submit a letter of appeal to the Clinical Standards Committee explaining the reasons for his/her clinic performance. This must be received by the Clinical Education Office by Tuesday morning of the first week of the term. If the Clinic Standards Committee approves the appeal, it will develop a plan for the intern wherein he/she should be able to meet SCP within a certain time frame. Following this approval, the intern will meet with a representative from the Dean of the Health Center to review and sign the clinical plan. Approval of probation status allows the intern to continue in his or her program.
Clinic Dismissal: If, after being placed on clinic probation, an intern fails to meet the standard of Satisfactory Clinic Progress and/or fails to meet any of the requirements of the clinic plan, he or she may be dismissed from the Clinic.

If an intern who has been dismissed from the Clinic at a later point re-applies to the Clinic, he or she must also submit a letter of appeal to the Clinical Standards Committee for readmission.

Appeals may be made based on the grounds:

■ A death in the immediate family.
■ Serious injury or illness of a student or a member of the immediate family.
■ Special circumstances to be reviewed on a case-by-case basis.

Clinic Honors Recognition of Interns

• Intern of the Quarter: The highest producing intern of the Health Center each quarter will be recognized as Intern of the Quarter upon the recommendation of his/her advisor. This intern is awarded a certificate during the quarterly Health Center Recognition Seminar.

• Honors Program: In this program interns are recognized for their performance based on patient visit numbers in excess of minimal requirements while remaining in good standing in the Health Center and campus environments. ‘Good Standing’ means that an intern has not had any disciplinary action, is not on contract with either the Academic or Clinical Standard Committees and has not had to enroll beyond the typical 6 quarters of clinic to complete their requirements.

Recognition will be awarded to interns who achieve patient visits of 350, 400, 450, 500 and more than 600.

• Interns are recognized for ALL patient category visits including: student, courtesy and outpatient adjustments.

• Note: the student (and student courtesy patient) adjustments are NOT counted towards the outpatient graduation requirements and only towards Honors recognition in the Honors Program.
Recognition will be awarded as follows:

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CLINICAL EXCELLENCE CITATION

The highest CLINICAL honor that can be bestowed upon a graduate is the Clinical Excellence Award. This award recognizes the student that has both skillfully and successfully found the combination of outstanding doctor-patient relationships, professional attitudes, clinical knowledge, skills and judgment.

Upon recommendation by the HC Administration Group, the intern is chosen on the basis of the following criteria and conditions:

- Completion of all clinical requirements
- Achievement of 350 or more patient visits on or before the last day of the second month of the graduation quarter.
- Review of the candidate’s number of Intern’s Qualitative Assessments graded as ‘Competent’ and ‘Proficient’ across all assessment types.
- Review of the candidates Health Center Advisor file, including any Notice of Praise or Notice of Concern statements and all Health Center examination results.
- Clinical knowledge and judgment
- Chiropractic adjusting skills
- Communication and interpersonal skills
- Professional attitude and behavior
- Quality of record-keeping
- Leadership
- Overall commitment to excellence
- Following review of the HC Advisor file, the remaining candidates must be approved by each of the Health Center department administrators (Competency, Quality Assurance, and Imaging).
- Final determination will be made by a vote of the Health Center Faculty and Administrators.

The recipient of the Clinical Excellence Citation will receive his or her award during the college’s HC Recognition Seminar and/or Graduation Ceremony.
The Administration of the College/Health Center reserves the right to add, delete, or modify the Health Center’s policies and procedures as needed.
PATIENT FILES

General Instructions

1. Every page must have the patient information and intern information filled out at the top.
2. All blanks must be filled out, legibly, using longhand and standard abbreviations only.
3. All writing in the patient files must be filled out in blue or black ink, no other colors. You may not use felt tip pens (including hi-lighters), pencil, fine point pens or erasable inks. If changes are necessary, cross out the error with one line, and initial the change. No whiteout or any other manner of erasing is permitted.
4. The Patient Information form, which is filled out by the patient, must be completed and signed by the patient or legal guardian. It is included in the case file as part of the permanent record. Read this form after the patient has completed it.
5. All forms are legal documents and must be completed with this in mind.

Page Order

Please ensure that each of your files conforms to the following page order:

On the right side of the file:

1. CMR Action page, most recent on the top.
2. S.O.A.P. Notes, most recent is on the bottom page of the SOAP note section.
3. O.A.T.S forms next to the day of the S.O.A.P. the O.A.T.S form was filled out.
4. Physical examinations (including initial exam, re-evaluations, transfer and/or re-activation exams) should have the most recent on top. Order of forms included in the History: Reason for Seeking Care form, Additional Complaint form(s) if applicable, OATS, Wellness Questionnaire, Review of Systems page, Case History Diagnosis Worksheet, exam forms, Summary of Findings/Imaging Request Form. For Re-Eval patients, the OATS should be inserted behind its corresponding Re-Eval sheet.
5. All labs will be next in the file. Labs should have the request and narrative in front of each corresponding lab. Most recent lab is on the bottom.

6. All radiology reports with most recent DACBR report relative to the spine being the last page of the file.

On the left side of the file:

1. Faculty Notes page(s)
2. Any referral forms should be placed directly under the Faculty Notes page(s)
3. Informed Consent(signed)
4. Patient Information Sheet and New Patient paperwork
5. Insurance information forms filled out at this Health Center.
6. HIPPA forms
7. All outside information/medical records, disability forms and open lab SOAP notes.

See mentor for information concerning Workers' Compensation and Personal Injury files.

SPLITTING A FILE

Patient Files may need to be “split” if the file gets too thick, or the folder is ripped so that forms could fall out. This procedure is also followed when an outpatient becomes a student or vice versa.

When a new folder is created on an existing patient, the following are included in the new file in the following order:

Left Side of File: All original forms from old file are put into the left side of the new file. This includes:

- Faculty Notes page (on top)
- Any Referral forms should be placed directly under the Faculty Notes page(s)
- Informed Consent(signed)
- Patient Information sheet and New Patient paperwork
- Insurance information forms filled out at this Health Center
- HIPPA forms.

Right Side of File: The following Original forms are kept in the new file:

- Recent CMR Action pages (can keep up to one or two years and the rest can go into the old file)
- Recent SOAP notes (Can keep the most recent intern’s SOAP notes and some of the previous intern’s SOAP notes)
- Physical Exams of the most recent intern of record exam (i.e., Re-evaluation Exam/s and Transfer exam) and one or two of the previous intern’s exams
- Laboratory report if less than one year old
- All radiology reports. The most recent DACBR report is the last page of the patient file.
The records room does not need to make copies of these forms that are kept in the new file to put in the file that goes to archives.

*This does not include starting a new Personal Injury File on an existing patient.

**Records of the Health Center**

Patient records are to remain within the Health Center at all times. Patient records (patient files and x-rays) may be checked out for use within the Health Center through the records room staff. The intern will complete and submit a red “out-guide” to the staff to be placed in the filing shelves when a record is pulled for use. The records must be returned to the records room the same day they are checked out.

Patients are not to be checked into the Health Center later than 45 minutes prior to scheduled Health Center closure; records are to be returned to the records room no later than 15 minutes prior to closure time.

**PT Equipment and Supplies**  
[Link to Supply List]

The Health Center maintains physiotherapy equipment in the records room. This room is located within the records room of the Health Center. The following are some items* available for patient purchases: heel lifts, supports, theraband, and ice packs.

The intern must make sure of the following:

- The items purchased must be included in the case management and approved at CMR.
- The mentor signs the visit slip at the time of the visit for the appropriate item.
- Faculty completes a heel lift form for heel lifts.
- The intern presents the visit slip (and heel lift form, if applicable) to the records room and they record the price of the item on the slip.
- The patient pays for the item at the cashier’s station.

*No item, other than those authorized in the CMR may be sold, provided, or recommended to any patient, unless recommended by a mentor under Acute Care Protocol. This includes nutritional supplements.

**PATIENT CARE PROCEDURE**

**New Patient Information/Forms**

All new patient intake forms can be found on the LCCW website at [www.lifewesthealthcenter.com](http://www.lifewesthealthcenter.com). Have new patients complete these forms, save to their desktop and submit to the Health Center. The completed forms will be emailed to the New Patient Desk and a new file will be prepared for the patient prior to his/her arrival. If the new patient has not completed these forms prior to his/her first visit, he or she can complete them electronically or on paper at the time of arrival. Please allow 30 minutes for this process before seeing the patient.
Online Forms Include:

Patients will be submitting the following forms to the front desk prior to their appointments. The intern should look through these and make additional notes as they are discussed with the patient on their first appointment.

**Reason for Seeking Care (i.e., Chief Complaint)**  
In case the patient did not fill out the paperwork prior to their appointment, use the Reason for Seeking Care Form for recording the patients complaints. In the event there is more than one complaint, use the History of Additional Complaint forms that are on the wall. Use as many forms as necessary.

Not all patient complaints are chief complaints. The chief complaint is the complaint which actually motivated the patient to seek health care. It may not actually be the patient’s most serious problem but it may be uppermost in the patient’s mind.

**Pain Diagram**  
The patient must mark all complaints on this diagram.

**Health and Wellness Questionnaire**  
The Wellness Questionnaire Form can be completed by patients prior to coming for their appointment, on the Life West web page. Review this with the patient and make follow-up notes on the bottom of the page, or on the Review of Systems (ROS) notes page.

**Review of Systems (ROS)**  
During the initial, transfer, or re-activation exam, the patient will complete this ROS Form and the Wellness Questionnaire prior to their appointment. This can be filled out by the patient online prior to their appointment. Any ongoing or significant issues need appropriate details which may be written on the following page by the intern while taking the history.

**Case History - Diagnosis Worksheet**  
The Intern will document the significant findings from the ROS, such as details regarding traumas, etc. The working Diagnosis(es) are listed along with the most likely conditions and differentials. Both the intern and the faculty sign this page and check off the required exams and OATS before the physical exam may begin.

**HPON (History, Physical, Ortho/Neuro)**  
These pages are actually a set of forms and the core of the patient’s file. They contain the following:

- Reason For Seeking Care/Additional Complaint(s)
- Pain Diagram, Wellness Questionnaire, ROS, OATS
- Physical, Orthopedic, Neurological, and Chiropractic Examinations
- Imaging Evaluation and Request
Physical, Orthopedic, Neurological, and Chiropractic Screening Examination

In completing the examination, be thorough, do not leave blank spaces on the Chiropractic Screening Examination Form, NAD = no abnormality detected. All abnormal findings require detailed comments on the blank lines provided at the end of each page. Note that in some areas “go to sp#__” indicates special procedures need to be performed. The special procedure form is found on the forms wall in the Health Center. Summary of Findings and Imaging Request

Summary of Findings and Imaging Request

The Summary of Findings and Imaging Request should be completed by the intern in consultation with the HC faculty following all initial, transfer, and re-activation examinations even if x-rays are not requested. Include all history and exam findings for all complaints. Faculty signature is required at the bottom of this page and on the visit slip prior to releasing the patient.

THE NEW PATIENT PROCESS

Prior to a patient’s first visit, the intern must schedule the new patient coordinator, new patient, initial exam, and x-rays (if necessary) in the MindBody scheduler for the new patient. If possible, have the patient complete the new paperwork online at www.lifewesthealthcenter.com. Spanish forms are available.

When a patient enters the Health Center for the introductory consultation and examination process, the following should occur:

- The patient presents to the receptionist for instructions (if the new patient paperwork was completed online and submitted, there will be a file ready for patient signatures. If this has not been completed, the new patient paperwork will be completed at this time and a file will then be compiled for the final information and signatures).
- The Chiropractic Assistant will page the intern when the file and visit slip are ready.
- The intern assists the patient to a consultation/examination room and completes the Patient Case History, Review of Systems and Wellness Questionnaire making notes as appropriate.
- After completing the Case History Diagnosis Worksheet, the intern will take the file to their mentor to select appropriate OATS forms and examinations.
The mentor will determine if the patient should follow the acute care procedures, personal injury protocols, standard care procedures, or requires immediate referral.

Once determination of protocol has occurred and OATS have been completed, a Health Center faculty signature authorizes the intern to perform the physical exam.

The intern may then proceed with the physical exam.

Upon completion of the examination, the intern completes the Summary of Findings and Imaging Request form, getting approval from the mentor to proceed. The mentor signs all appropriate forms.

Necessary x-rays are taken or appropriately scheduled. The x-ray department faculty initials all appropriate imaging forms.

The patient presents her/himself to the cashier line for processing of the charges/payment information and intern credit input.

RE-ACTIVATION PATIENT PROCESS

Re-activation: Any patient file, having been inactive for more than one year but less than three years, requires a complete history and examination. This is true even when there is no change in the intern of record. The following examples would be considered a re-activation:

- One year since last patient visit.
- File had been previously inactivated.

The procedure will be the same as if the patient is a new patient. Patients who have been inactive for three years or longer are considered as new patients and if recruited back to the Health Center by the intern, will count toward the 10 New Patients required for graduation.

TRANSFER PATIENT PROCESS

When a student patient is transferred to a new intern, the intern of record should introduce the new intern to the patient as well as let the patient know that their case has been discussed with the new intern. It is also highly recommended that the new intern observe a visit so that the patient is confident that the new intern is familiar with all aspects of his or her case.

When a student family, courtesy, or outpatient is going to be transferred to a new intern, the intern of record must introduce the new intern to the patient as well as let the patient know that their case has been discussed with the new intern. It is also required that the new intern observes a visit so that the patient is confident that the new intern is familiar with all aspects of his/her case.

Notation of the new intern observation of a visit will be made in the S.O.A.P. notes and initialed by the mentor at the time of the visit. It is highly recommended that the new intern also provide care for the patient on an OTO-basis prior to transfer of the file. The new intern of record may then schedule a transfer exam with the patient.

Transfer Process (These first three steps may occur prior to the patient arriving for his/her first transfer visit):

- As the transfer patient arrives for the exam and obtains the visit slip, the intern proceeds to the records room and gets the transfer clipboard.
The intern writes the appropriate information onto the form and brings it to the mentor to sign off the transfer.

The intern gets the approval of their mentor who will then assign the patient to the intern in the faculty notes.

The intern assists the patient to the consultation/examination room and proceeds with the history and exam, obtaining signatures as needed as in the new patient process.

The new intern of record is allowed to see their patient up to 4 times as they are completing the history and exam and prior to the CMR.

If the mentor agrees to the visit, the mentor writes transfer visit (TV) next to the SOAP Note and on the visit slip.

The Transfer Visit (TV) must be approved before the intern begins writing up the S.O.A.P. note for that visit. The new intern must follow the prior intern’s approved case management plan until the new CMR is completed.

**THE ACUTE CARE PATIENT AND PROTOCOL**

The acute care patient is one who has severe pain of recent onset or exacerbation that prevents them from engaging in their normal daily activities. The condition of the patient must be supported by the objective findings of the examination. The patient’s status is verified by, and each subsequent visit must be cleared through the mentor. The following protocol is observed:

1. Prior to assigning acute care status the intern should obtain a history of the chief complaint, review of systems, and pain diagram.
2. After completion of the history, the file is brought to the mentor who will determine if the history suggests acute care status. If the mentor feels the patient may qualify for acute care status, they will meet the patient to verify.
3. If the mentor decides the patient is acute, the intern will then perform a regional exam of the area of chief complaint (blue form) as well as take vitals. Additionally, as much of the full physical exam as possible should be performed at this time.
4. Upon completion of the initial exam, the mentor will approve necessary x-rays of the area of chief complaint. These must be taken prior to care. All attempts will be made to fit acute care protocol films into the imaging department schedule for that day.
5. The mentor will supervise or provide the acute care until the patient’s exam is completed and has gone through CMR.
6. Within two (2) to three (3) subsequent visits (or as soon as is tolerated by the patient), the intern should repeat the regional exam and the remainder of the physical exam.

**Minor Patients**

Individuals, who are 17 years old or younger, if accepted as patients need appropriate written parental/legal guardian authorization. Parent/legal guardian must be present with the patient in the room for all procedures. X-rays are taken based on clinical need and only with parental consent, following a complete explanation to the parent/guardian regarding x-ray exposure, technique alternatives, etc.
Sample of the LCCW Health Center’s Pediatrics Exam

We have two pediatric exams. This one is completed if the patient is a baby and up to one year old. Pages 1-2 of the Pediatric Exam can be given to the patient’s parent or guardian to complete prior to the visit, on www.lifewesthealthcenter.com.

Pregnant Patients

Patients who are pregnant may be accepted as patients for chiropractic care. X-rays are taken only if there was recent trauma, in which case only minimal x-ray studies are taken.

Trauma Patient Protocol (Personal Injury)

The intern is to immediately notify their mentor in the event that a patient presents with a history of recent trauma. It must be determined if the case should be assigned a personal injury case. A complete history of the incident must be taken, documented, and discussed with the mentor before further orthopedic or neurological testing, care, or ancillary procedure is provided to the patient.

Personal Injury

Although it is always necessary to adhere closely to the Health Center protocol, it becomes especially important to do so in Personal Injury cases. These cases, for various legal reasons, require an increased amount of documentation and precision in record keeping. The patient may be seriously inconvenienced in terms of the legal outcome of the case, should the Health Center fail to manage the case in an appropriate manner. The Health Center and individual mentors are equally exposed to unnecessary problems should the intern fail to carry out their responsibilities properly.

Interns who collaborate with D.C.’s on these challenging cases are afforded an excellent opportunity to obtain a great deal of on-the-job training in chiropractic injury protocols. It is with this in mind that interns carefully read and adhere to the protocol described below.

Determination of a Personal Injury case is best made before or during the initial consultation. The patient may have informed the Health Center receptionist or other chiropractic assistant on entrance or may have included a notation on our patient intake forms. If there is no indication of injury, it is still appropriate during the consultation to ask, “Have you been hurt at work or have you been in an automobile accident or some other kind of accident?” The Health Center no longer accepts Workers’ Compensation cases and will refer the patient to a chiropractor in the field if necessary. If the patient reports that their condition is associated with their job the mentor should be consulted immediately.

The intern is to notify the mentor immediately when injury is suspected. Documentation of the injury or suspected injury then becomes necessary concerning the circumstances of the case: where and when it took place, whether a report was filed, and the name and address of insurance carrier/attorney.

Some patients prefer that their job-related or auto accident injuries remain unreported. In all cases, the mentor will interview the patient and make notes in the file indicating the appropriate course of action.
Personal Injury patients can be accepted and approved only by the Mentor. The intern, under the direction of the mentor, is responsible for completing all normal and additional procedures relating to the case including:

- Phone calls for miscellaneous information
- Supplementary forms and reports
- Narrative reports, supplementary examinations and Imaging Request (Supplemental)

HIPAA (See Section 3)

CASE MANAGEMENT REVIEW (CMR) PROCESS (Sample page)

Case Summary Narrative (Sample pages)

All initial, transfer, and re-activation narratives are to be written using the most recent narrative templates, which are on Canvas. Patient name must be handwritten with last name first, the full first name. The most current narrative templates are found on the intern Canvas page, 2nd floor of the Health Center.

X-ray Narrative Report

Lines of mensuration are required on all spinal images. Record your interpretation of the x-ray findings in ABCS format within the body of the narrative. This includes an x-ray impression.

The CMR process is an evaluation tool. This is a one-on-one consultation between the faculty and the intern to discuss all aspects of the patient’s file, care, and progress. It measures the intern’s ability to evaluate the patient’s condition, to arrive at a diagnostic conclusion, and to develop an appropriate care plan and prognosis. In addition, it is an ongoing measurement of the intern’s proficiency, since the CMR interview is conducted for each physical examination, laboratory and x-ray. A CMR Review Assessment is completed for all CMR meetings relative to initial exams, transfer exams, and re-evaluation exams with a new complaint in order to assess the intern’s proficiency.

The Health Center faculty will review the patient file and question the intern on the diagnosis and course of care suggested. When the faculty is satisfied that the intern’s diagnosis and case management plan is appropriate and complete, approval to begin or continue care for his or her patient is granted. Patient care may be delayed if all necessary information has not been completed or brought to the CMR appointment.

Instructions for the CMR Action page

You will cut and paste the information for the CMR Action Page from your narrative. Please keep it in the order that is on the CMR Action Page template. Delete the supporting information that you listed for your condition/Diagnosis. (For example: keep Lumbar Facet Syndrome as part of your Problem list/Diagnosis but delete from this page the findings that support it; i.e. pain on extension, Kemp’s caused left low back pain into the buttock, etc.). Your differentials do not need to be included on this page.

Make sure you fill out the header information, leaving the patient name blank. After you print the page, fill in the patient’s full name putting last name first.
You only need to print one copy. After you have been through the CMR process and it has been signed, make a copy for HC Registrar and a copy for the patient. If it is two pages, you only need the first page for HC Registrar and possibly for your patient. The records room will make the copies for you.

CMR Appointments and Procedures

CMR appointments are made each time a patient, student or outpatient, is examined by an intern. CMR’s are required after every initial, transfer, reactivation and re-evaluation exam. Re-evaluation exams that do not include a new complaint do not require a CMR appointment.

General Points:

- All CMR’s require the appropriate documentation, i.e., visit slips, to verify that the history, exam and x-rays, if taken, has been completed.
- All CMR’s require a completed checklist. After the CMR checklist is completed by the intern it must be checked by a mentor doctor. Once that is complete the intern is to take the checklist to the front office staff to schedule a CMR appointment.
- CMR appointments cannot be changed or cancelled within 6 hours prior to the appointment.
- If the intern does not show up for their scheduled CMR appointment, they will lose 5 student or outpatient adjusting credits, depending on clinic level.
- An intern cannot sign up for more than two CMR’s a day.
- The mentor will be completing all CMR’s on their Medicare, Personal Injury files as well as their interns’ students’ re-evaluations.
- CMR’s for Outpatient and Student Initial, Transfer and Reactivation Exams are performed by HC Faculty (CMR Docs).
Most CMR appointments for a new patient or transfer exam are between 30 to 45 minutes, depending on the complexity of the case.

The CMR should be completed within 5 working days after the patient is assigned to the intern.

CMR’s will be completed with the scheduled CMR faculty. X-ray listings and CBP traction protocols need to be reviewed with appropriate doctors before the CMR appointment.

The upper cervical technique’s listings are written in the Faculty Notes by the approved faculty prior to the CMR.

Similarly, traction protocol and frequency of visits needs to be approved by the CBP faculty and initialed on the CMR Actions page prior to the CMR.

Re-evaluations with a new complaint, are scheduled with the CMR faculty. The intern will not receive credit unless these are scheduled with CMR Faculty.

CMR’s for Re-evaluation exams on outpatients only: the visit slips go into the file and the interns give the file to the records room staff and tell them to put it on the Re-evaluation shelf. These are completed by the CMR faculty on a daily basis. *Student Clinic 2 interns must schedule in-person re-eval CMRs.

CMR’s for Re-evaluation exams on Student patients only; Please see your mentor to determine how they are scheduled.

Blue Dots: If more information is needed in the file, a blue dot will be placed on the patient file by the faculty who are completing the CMR. A blue dot means that there is some information missing in the file that the intern needs to complete. Interns have two weeks from the time the blue dot is put on to complete the file. Interns should see their practice mentors (mentors) for further instructions. Interns should bring the file back to the CMR faculty who put the blue dot on the file to make sure the file is complete.

Writing a Clinical Impression/Diagnosis

A diagnosis at the Life West Health Center shall be written as a prioritized problems list. The final diagnosis is determined from all the information obtained as a result of history, physical examination, x-ray examination, labs, and any special studies. The diagnosis shall include, but is not limited to, subluxations of the spine/pelvis and/or extremities, all conditions relative to the chief complaint(s) and additional complaints. In addition, incidental findings, co-morbidities and all conditions that are to be referred out or co-managed with another health care provider. All descriptors (i.e. acute, sub-acute, chronic, mild, slight, moderate, severe, occasional, intermittent, frequent, and constant, etc.) are to be used when appropriate.

The following is a description of how to write the diagnosis in the patient narrative.

Diagnosis/Problems list: The diagnosis should be grouped by complaint with each complaint listed separately based on the patient’s priority.

Complaint with applicable modifiers

Subluxations of: list level(s) of area of chief complaint (upper, mid or lower - within a region)

Neurological Diagnosis: Write condition causing patient’s complaint. This condition was considered due to (relevant information from the patient’s history). It was confirmed by (information obtained from the exam and pertinent radiographic imaging).
Structural diagnosis(es): from x-rays that pertain to chief complaint i.e., DDD L5-S1, facet sclerosis, scoliosis, spondy

Functional diagnosis(es): i.e., aberrant posture, indicate what type, i.e. upper cross, lower cross, cervical hyperlordosis

Soft tissue diagnosis(es): for region sprain/strain, muscle spasm, myofascitis, bursitis, tendinosis/itis, etc.

Co-morbidities: These are health considerations or habits that make it harder for the patient to heal, i.e. smoking, diabetes, obesity, heart disease. This does not include family history issues.

PROGNOSIS & GOALS

PROGNOSIS—support your choices based on the following guidelines.

1. Symptomatic prognosis:
   - How severe and frequent the symptoms are at intake. More severe symptoms generally take longer to resolve
   - How long the symptoms have been present. The shorter the time, generally the better the prognosis.
   - Number of areas of complaints. The more going on with the patient, the longer it takes the body to heal.

2. Functional prognosis:
   - Lifestyle: bad habits, sedentary lifestyle make it worse
   - posture
   - co-morbidities may make it worse
   - age
   - job requirements
   - Include an OATS scale expectations. A low (OATS) score would make the prognosis good to excellent

3. Structural prognosis is based on abnormalities found on posture analysis and/or x-rays
   - Minimal DJD or DDD, the prognosis is probably good
   - Spondylolisthesis may be fair to good, depending on how stable it is.

DEFINITIONS FOR SYMPTOMATIC AND FUNCTIONAL PRONGNOSES

EXCELLENT—Resolution (90-100% improvement) of problem expected in average or faster than average time frame.

GOOD—Improvement (60-80%) expected and will take average amount of time for healing and change to occur.

FAIR—Some improvement (about 25-50%) expected but will take longer than average.

POOR—No improvement expected.
GOALS

Goals must be specific and measurable which means there should be numbers involved.

1. Functional goals: “increase lumbar flexion by 10°” or “increase ability to single leg stance to 60 seconds” or “decrease anterior head carriage by 1 inch” or “improve RM-LB score to minimal disability”.

2. Pain goals should address intensity of pain and frequency of pain.

REPORT OF FINDINGS  (See Section 2 - Page 57)

AUTHORIZED TECHNIQUES

Only the techniques and analysis procedures taught in the LCCW Technique Labs are allowed in the Health Center.

An intern must have successfully completed on-campus course work in a given technique prior to using that technique in the Health Center. The intern will receive authorization to use elective techniques from the Health Center Registrar reflected on their ID badge.

At least 150 of the required 300 patient adjustments must be made using techniques from the core technique curriculum. These techniques include Diversified, Gonstead, Integrated Drop Table, and Toggle techniques. The remaining 150 adjustments may be made using elective techniques for which the intern is qualified. These techniques include Activator, Chiropractic Biophysics (CBP), S.O.T., NUCCA, Evolutionary Percussive Instrument Correction (EPIC), Blair, and Upper Cervical Knee Chest.

The visit slip has a separate designation for the elective technique adjustments and the intern credit report will indicate the number of elective adjustments performed.
Ancillary Procedures (Physiotherapy)

No physiotherapy modality may be used until the PT Modalities course has been passed. Pre-authorization is required for all PT use during the CMR and must be approved by the faculty at the time of each visit. The instrument, settings, duration of treatment and area of treatment will be documented in the case management plan, and approved by faculty during the CMR. All applications of PT must also be documented in the visit record (i.e., SOAP note) and are posted on the visit slip. SOAP note documentation includes the area it is being applied to, duration of the application and instrument.

All PT applications are to be approved and observed according to normal Health Center standards and procedures. A patient may not be left unattended during the use of any modality. PT is provided only in conjunction with specific chiropractic care: either preparatory to or subsequent to, but never in lieu of, chiropractic adjustments. To check out PT equipment: complete the S.O.A.P. notes, have authorized on the SOAP note by the faculty and obtain the equipment from the Records Room. Faculty will sign the visit slip after the PT has been performed. Interns need to leave their keys/property to take out PT equipment.

Documenting PT in the File:

Your specific settings should be spelled out in your case management plan in your Narrative. In your SOAP notes, you need only put the modality, the amount of time you will be applying it, and the area you will be applying it to in the P portion of the SOAP note. The Objective portion of the SOAP note must support the need for the modality.

Prior to performing any PT:

- You must have it written in the file on the CMR page and in the SOAP notes
- You must have it initialed by faculty in the SOAP notes for the Records Room to provide you with the appropriate modality.
- After the PT has been provided to the patient, the faculty will sign the visit slip.

If you want to add PT that is not in your case management plan, you may ask the faculty for a one-time trial. After that, if you wish to add it to your care plan, you must sign up for a CMR.

If PT is being performed on an outpatient, it must be done in the practice areas or PT area. If PT is being performed on a student, it must be done in the student health center during regular student health center hours.

INFORMED CONSENT

In the state of California, Informed Consent must be completed by a licensed chiropractor. The Informed Consent form is signed by the patient after the ROF and before the first adjustment. Informed Consent Instructions:

The Informed Consent to Chiropractic Care form is to be used on every new patient at the time of the Report of Findings BEFORE care is provided to the patient. The faculty must mark on the form the procedure(s) that are part of the approved care plan. The patient must read the Informed Consent form and a licensed Health Center faculty doctor must verbally explain the risks and benefits of chiropractic care to the patient. The patient checks the box indicating that they have read or had read to them the Consent form and then both the patient and doctor print and sign their name, once the patient understands and has had their questions answered. The intern checks off procedures or modalities he/she is including in the case
management plan and explains these to the patient. The patient then initials each of these in agreement.

In an Acute Care Case, the form MUST be read, explained, and signed BEFORE any care is provided. Any licensed Health Center faculty doctor can explain and sign the form; it can be a covering faculty doctor in the absence of the assigned faculty mentor. Once the Informed Consent form is signed, then a copy is made. The original goes in the file behind the Faculty Notes page and the copy is given to the patient. If the care plan is changed to include any procedures that were not checked on the original Informed Consent form, then that procedure must be marked, initialed, and dated on the form behind the Faculty Notes page. The risks and benefits of that procedure must be explained to the patient, the form must be resigned and dated by the patient and faculty, and a copy given to the patient.

**Patient Visit Slip**

This form is the single most important form to ensure accurate patient financial accounting and intern credits!

The Health Center receptionist will print a visit slip for each patient. The visit slip includes the patient’s name and account number, the date, the intern of record and doc code, the current diagnosis, etc. This information is essential to the record-keeping program of the Health Center. It creates accurate billing records, patient statistics, and tracks graduation credits.

Health Center faculty and staff are given authority to indicate which procedures have been provided. This ensures that the patient is billed appropriately and the intern’s credits are correctly recorded.

The visit slip is printed in duplicate. The visit slip is to be returned to the Chiropractic Assistant at the end of the patient visit. The intern must keep the pink copy for credit. Visit slips should always be turned in at the end of the day even if an adjustment was not performed. Patients may request a printed receipt as evidence of the visit, procedures, and charges.

**Office Visit/Adjustment Procedure**

- The patient checks in and receives a Patient Visit Slip (also called Visit Slip).
- Student patients may not check in at the front desk until 12:20 but their intern may sign up in advance (before 11:30) to have a visit slip pre-printed.
- The intern checks out the patient’s file and any other appropriate records.
- The intern greets and assists the patient to the appropriate area.
- If the re-evaluation is due or past due, intern must obtain permission to adjust the patient from faculty before starting the SOAP note.
- The intern provides the examination procedures appropriate to the subjective, objective, assessment procedure and completes a thorough write up in the patient record.
- The intern requests approval of their care plan for the day by their mentor. In the Student
  - Health Center approval is made by the assigned faculty.
- Care is approved by the faculty doctor initialing the patient file on the S.OA.P. note for that date. The faculty doctor initials the Patient Visit Slip once care has been provided.
When the visit is concluded, the patient presents to the cashier with the visit slip for payment and processing. The patient may check his or her financial account and make any appropriate payments at this time.

All patient care must be performed in the Health Center. Patients cannot be taken to the Fitness Center for exercise instruction.

**EQUIPMENT** *(See Section 3)*

**RE-EVALUATION EXAMS** *(Sample page)*

Periodic re-evaluation exams are performed to track the patient’s response to care. When a re-evaluation is performed the same day an adjustment is given, the re-evaluation is completed before the adjustment. There are 2 types of re-evaluation exams, a progress re-evaluation and a re-evaluation with new a complaint.

**Progress Re-Evaluations** *(Sample page)*

A Progress Re-Evaluation is provided to the patient on or before the date at the bottom of the CMR Actions Page. Care on the day the re-evaluation is due is the final day that care may be given without an Authorization to Adjust (ATA) until the re-evaluation examination has been completed and brought through CMR. It is at the faculty’s discretion whether an ATA is approved.

- The intern informs the patient that the next visit will be a re-evaluation exam and they will need to fill out the Online Health and Wellness Questionnaire prior to coming in that day. These forms are located on our website at www.lifewesthealthcenter.com
- On the day of the re-evaluation, the patient will fill out the appropriate OATS form(s), and the “Give Us a Grade” form. The patient also fills out the ongoing complaints with updated information on the top part of page 2 of the Re-evaluation form.
- The intern performs a complete vital sign examination.
- The intern is required to complete inspection, palpation, and range of motion for all areas of the spine and areas of extra-spinal complaints.
- Complete orthopedic and neurological examinations of all areas of the complaints are required and positive findings documented.
- The results of all previously positive findings and significant negative findings from the most recent exam must be documented whether positive or negative.
- The mentor signs the re-evaluation form on the day it is done, verifying its completion and initials the procedure on the visit slip.
- If the re-eval is overdue, the intern is permitted to continue patient care only with an ATA, provided the previously approved case management plan is followed and the patient has not suffered a trauma or significant change in symptoms.
- The ATA must be obtained from the HC faculty after the re-eval exam has been completed and prior to beginning the SOAP note or there will be no credit for the adjustment.
- The intern has one (1) week from the time of the re-eval to complete the Narrative and submit the file for CMR.
- The DACBR Reports must be included in the file by the time of the first re-evaluation CMR.
- All previous blue dotted items from the intern of record must have been completed.
- The completed exam, narrative, case summary, and a completed check list and a copy of visit slip are all required before the file can be dropped into the re-eval tray in the Records Room.
- Medicare (blue) files must have a scheduled CMR with practice mentors.

Re-eval with New Complaint

Any time a patient reports a new complaint or new injury, a History of New Complaint and a focused exam must be completed. If the patient’s re-eval date is soon due or if the patient reports the new complaint at the time of the re-eval, or if the new injury or complaint affects the previous complaint, the intern should complete both the yellow re-eval form and the blue history of a new complaint with appropriate OATS and focused exam. The mentor makes the decision regarding which focused exams to do. The procedure is as follows:

- All patient procedures prior to date of the re-eval are the same as written under Progress Re-evals.
- The intern completes the yellow re-evaluation form, the blue history form and new OATS, which are found on the form shelves within the student computer areas on floors one and two, and on the forms wall in the student clinic, or with the mentor.
- Intern uptains faculty signature on back of the blue history form.
- The intern completes a focused exam on the area of the new complaint and has the Health Center faculty review when completed. At this time the Health Center faculty signs the yellow re-eval form, the exam form, and the visit slip.
- New X-rays and labs are authorized and ordered as appropriate.
The patient can be released at this point.

The intern then writes the narrative report for the new complaint. This includes history, diagnosis with the exam findings that support it, and DDX, prognosis, and goals of care. There is a template for a re-eval with a new complaint on the computers in the Health Center.

The re-eval narrative regarding the previous complaint(s) is also completed using the most recent updated narrative template on Canvas.

The intern completes a new CMR Actions page.

All re-evals with a new complaint require a scheduled CMR with the CMR faculty.

If the patient reports a new complaint or new injury shortly after their progress re-eval has been done, it may only be necessary that the intern complete the blue history, with appropriate OATS and exam. The procedure is the same as above with the exception of the yellow form. The re-eval date given at the CMR should be the same as the old re-eval date if appropriate. The patient is to be charged for a re-evaluation in either case.

**Give us a Grade** (Sample page)

Intern has the patient fill out this Patient Survey Form and then brings it to the Front Desk. The patient should fill this out while the intern goes to get faculty signatures.

**Inactivations**

There are two (2) ways in which a patient file is inactivated:

1. The intern goes to the Health Center mentor to request that the file be inactivated.
2. More than one year has elapsed since the patient’s last visit

In the first instance, the intern enters the reason for the inactivation on the last SOAP note form and then brings the file and the inactivation sheet to their mentor. In the second instance, the patient’s records are pulled from the active file cabinet, appropriately documented, and archived by the Records Room staff.

The fact that a patient file becomes automatically inactive due to inactivity does not absolve the intern of the responsibility to have formally inactivated the file nor of their responsibilities to the patient, the patient’s records, or to the Health Center.

Inactive records are archived for 7 years and are retrievable when necessary. Interns checking out of the Health Center must transfer or inactivate all patient files with their mentor. An LCCW student’s patient file cannot be inactivated until their graduation.

**CHANGE OF TECHNIQUE**

In order to change the technique or care plan for any patient, a face-to-face CMR must be scheduled. If applicable, perform the re-evaluation examination, take and evaluate necessary x-rays and complete an updated narrative & CMR Actions page. Until the new care plan is approved, only the approved care plan, frequency & duration may be performed on the patient. Once the care plan has been updated, an updated Informed Consent must be delivered by a HC faculty and signed by the patient.
PATIENT REFERRALS

Patient Referrals must be completed with Health Center faculty supervision. All patients, who require a referral for immediate emergency care, additional examination/testing, or co-management, are given a referral form with the findings indicating the need for management outside of, or in addition to chiropractic care. The form is signed by the intern, the patient, and a Health Center Faculty Doctor. The patient receives the original and copies are placed in the patient file and sent to the intern’s Mentor, as well as to the Compliance Officer.

Once a month, the Compliance Officer will audit the referral files to determine if patients followed through with the recommended referrals. If nothing is documented in the file, then a referral follow up form is sent to the Mentor, who then meets with the intern to determine what has been completed and documented in the SOAP notes, and what may need to be followed up on.

Clinical Laboratory Requests

Lab Requests

1. Intern fills out the LCCW lab request form; the practice mentor will review and sign it.
2. Decide if the patient will be private pay (using the LAP draw and test fees) or if lab will bill insurance (use the comprehensive fee schedule).
3. Practice mentor completes the Lab Corp requisition form and includes the individual testing fees and draw fee, and the total amount the patient will owe. A sample is included in the lab notebook. Don't forget the diagnosis codes!
4. Patient is given the requisition EBL form and a copy of the Lab Corp locations. The patient can also reference www.labcorp.com for phone numbers and other locations. The patient will fill out their name and address on the form.
5. Patient will go to the lab and have their blood drawn. Please let the patient know if they will be fasting or not prior to the blood test.
6. Lab Corp will fax the Health Center Specialist the results, who will review and bring to the Records Room to be filed into the patient’s file.
7. Intern reviews the results and writes the findings and their interpretation of these findings on the bottom the request form.
8. Intern schedules a 15 minute CMR appointment with faculty.
9. If faculty believe the lab results warrant a referral, the patient referral form is completed with and signed by the patient.
10. A copy of the referral is kept in the patient file behind the faculty notes page.
11. The intern will follow up with the patient to ensure he/she has visited with their MD and treatment was provided.
12. The lab results get filed on top of x-ray findings in the patient file.

Clinical laboratory credits are also given on laboratory tests ordered through Lab Corp or received from an outside source, on the intern’s assigned patient. These lab results and/or their credits are not transferable to another intern. Credit is given at the time of CMR evaluation.
Lab Request Form  (Sample page)

This form is to be used when an intern requests lab work to be done on a patient. The intern is not allowed to request lab work that has not been pre-approved by a HC Faculty. After signing this form, the faculty will authorize the release of the Lab Requisition book from the Records Room.

Space is provided on the form for a brief narrative concerning the results. The results of these procedures are to be taken through CMR within two (2) weeks from the date the lab work is received.

OUTCOME ASSESSMENT TOOLS AND SCREENS (OATS)

Functional assessment questionnaires give the interns and their Mentors qualitative data regarding the patients’ condition(s) that is tracked over the course of their care plan to assess progress or lack thereof. It provides objective data based on the patient’s subjective reports. The results of these OATS provide qualitative data showing how care impacts the patients’ lives in day-to-day functions. The following are evidence-based measurement tools that have been validated by outside research.

The following OATS will be available for use in the Health Center as appropriate:

All patients other than wellness patients (as well as Medicare patients)

McGill Pain Questionnaire (short form) with a pain diagram, will be used for the patient to mark his/her area(s) of complaint(s) (Sample)

*Given at initial and Re-eval exams to track along with an accompanying functional OAT

Cephalgia (Sample)

Headache Disability Index (HDI) for patients complaining of headaches,

Migraine (Sample)

Migraine Disability Assessment Questionnaire (MIDAS) for patients complaining of migraine headaches

Peds MIDAS for children and youth ages 4-17 complaining of migraine headaches (Sample)

Cervical complaint (or cervicalgia) (Sample)

Neck Disability Index (NDI) for patients suffering from neck pain or whiplash.

General pain or Thoracic spine complaint (Sample)

Pain Disability Index for patients whose only pain is in the mid-back, and/or generalized pain (as in fibromyalgia)

Lumbopelvic complaint (Sample page)

Roland Morris Disability Questionnaire for patients complaining of low back complaints.
**Upper Extremity complaint**
Disabilities of the Arm, Shoulder and Hand Questionnaire (DASH) for patients complaining of upper extremity complaints *(Sample)*

**Lower Extremity complaint**
Lower Extremity Functional Scale (LEFS) for patients complaining of lower extremity complaints *(Sample)*

If Depression or Anxiety is checked by the patient on the Wellness Questionnaire.

Patient Health Questionnaire (PHQ-9) will be used for patients admitting to depression on the Wellness Questionnaire who are not currently being medically managed. *(Sample)*

General Anxiety Disorder Scale (GAD-7) will be used for patients admitting to anxiety on the Wellness Questionnaire who are not currently being medically managed. *(Sample)*

**General instructions:**

1. Patients (except asymptomatic patients) will mark ALL complaints on the initial intake paperwork documenting all areas of complaint on the Pain Diagram.
2. All patients (except asymptomatic patients) will fill out the McGill Pain Questionnaire at the initial exam and each re-eval exam for the chief complaint only.
3. In addition patients will need to fill out at a functional OATS form pertaining to their area of chief complaint.
   - If a patient presents with multiple ‘chief complaints,’ he/she will be asked, “If we could only treat one complaint, which one would you want treated?” or, “Which one of your complaints bothers you the most?”
4. Interns may choose to have the patient fill out more than one McGill Pain Questionnaire or functional OATS form.
5. The OATS are listed on the Case History Diagnosis Worksheet. Interns and their Mentors will have the patient complete the appropriate OATS prior to doing the patient examinations.

*These OATS will take the place of the General Pain and Disability Index Questionnaire (GPDIQ)*

**Procedures for Anxiety/Depression Response on Patient Questionnaire:**

When a patient is experiencing anxiety or depression currently:

1. Ask if they are currently under treatment (meds or therapy). Ask if they feel like current treatment is working. If no treatment, or treatment is not working:
   a. Have patient fill out the PHQ-9/GAD-7.
   b. If score is above 10, give patient a list of Mental Health Referrals.
   c. If score is above 5, include walking or other aerobic exercise in management plan. Also, consider nutritional component.
2. Make sure to fill out referral form if giving Mental Health Referral list. Document information and follow-up in the SOAP notes.
3. Have patient fill out the PHQ-9/GAD-7 at least once a month until it is below a 5.

**Contraindications/Red Dot Procedures**

A ‘red dot’ is placed outside of a patient file, and in the Faculty Notes page to alert both interns and faculty that some comment or contraindication to patient care exists. The contraindications/condition will be explained in the Faculty Notes and signified with a red dot. A red dot can only be removed by the doctor who placed the red dot. For more information see Peer Review in Section 1.

**Examination: Gynecological/Proctological Exams**

Whether requested by the patient or deemed necessary by the intern, the interns of LCCW Health Center do not provide female breast or vaginal examinations and/or male prostate examinations. The intern is to consult with the mentor for the proper procedure for referral.

**PATIENT EDUCATION**

Since an understanding of Chiropractic and its relationship to their condition is important for patients to fully participate in their care, it is the policy of the Health Center that all patients be encouraged to attend patient education lectures available through the Health Center. This activity fosters long-term patient education. There will be opportunities to lead and assist in Healthy Lifestyle Classes that new patients will be required to attend, to participate in Community Health and Corporate Talks, as well as attending Chamber of Commerce meetings given on and off campus. Please see your mentor for information regarding these marketing events.

**Healthy Lifestyle Classes:**

Instructions for Healthy Lifestyle Classes

Healthy Life Style Classes (HLC) are to be given in a specific format using the power point presentation prepared and provided by the college. HLCs should be about 30 minutes in length. All patients who attend HLCs can receive a coupon for one free adjustment (this coupon is valid only for one week). All patients who are referred by an existing patient that is attending HLCs will receive the initial exam for half price if that exam is begun within thirty days of the presentation. All HLCs will be given in the HC waiting room using the flat panel display screen.

**Instructions for presenting Healthy Lifestyles Classes:**

At least one week prior to the talk: If you have not received a copy of the HLCs power point program, they are available on all library computers. Go to the library and copy the program either to a CD or a flash drive. (Ask the library staff for assistance if you cannot save the program)
If using your own laptop:

- Test its compatibility with the flat screen display station in the HC waiting area (instructions for connecting the laptop to the flat screen are included below).
- Practice the presentation to ensure it displays properly.
- If using a library laptop: Read and sign the “Laptop Agreement Form” This agreement stays on file in the library. You only do this once.
- Make an appointment with audiovisual staff for a training session if you need more familiarity with the laptop or PowerPoint remote control.

Review the notes that are included for each screen of the presentation. These notes are not a script, but some ideas of what could be said with each screen. It is a good idea to interact with your audience as much as possible, so consider how you may do so as you study the presentation. Practice the presentation out loud a few times. This will help you feel comfortable and familiar with the presentation and will help you with the timing as well. If you have questions regarding the presentation, please contact the Dean of the Health Center.

To print the notes associated with the presentation,

- Open the presentation
- Using the toolbar, click “file”
- Click “print”
- On this screen, under “print what”, select “notes pages”
- Click “OK”

Practice, practice, practice

On the day of the presentation:

At least one hour before the presentation,

- If using the library’s laptop, check out laptop # four and a power point remote control from the library (Laptop # four is reserved for use during all scheduled HLCs presentations. The HLCs power point presentation is loaded on this laptop in both English and Spanish).
- Get the HLCs referral clip board and coupons from the Dean of the Health Center’s office.
- At least thirty minutes before the presentation, arrive with laptop, remote, and HLCs clipboard with referral sheets and coupons.
- Set up laptop for use with flat screen display panel in HC waiting area.
- When facing the flat screen and table in HC waiting, the power outlet for the laptop is behind the table and to the left. Connect AC power cord to laptop and then plug in (do not use battery power if using library laptop, the computer will likely run out of power before you complete your presentation).
- The cable connection from laptop to flat screen is already connected to the flat screen. The cable is behind the flat screen wrapped behind and above the flat screen with the loose end on the right side of the screen between the screen and the right speaker. Bring this end from behind the screen down to the table on the left side. Attach the cable to the fifteen pin female connection on the laptop (this connection is blue on the library’s laptop # four).
Start the computer (do not start computer until the connection from computer to flat screen is completed as above). If the flat screen is not already started, start by pressing the power button located along the bottom of the screen near the right side.

Laptop # four requires a user name and password in order to complete start up. The user name is “anyone” and the password should be left blank.

While the lap top is starting, set up four to eight chairs (more if you think you will need them) in front of the children’s area facing the flat screen.

Once the lap top is started, change the source input for the flat screen. This is done by pressing the “source” button one time. (The flat screen is usually on PC1 for regular HC use, if pressing the button once displays any other source than PC2; continue to press the source button until the screen displays PC2) The source appears briefly at the upper left of the screen and is PC2. The button is located along the bottom of the screen near the right side and is labeled “source”. If the computers image is not displayed on the flat screen and you are sure that the flat screen source is PC2, if using laptop # four, press the Fn and F8 buttons on the laptop at the same time. If using your own laptop, you need the image to be projected to both the lap top screen and the flat screen. Most lap tops have as one of the function keys crt/lcd. Choose the key that will allow you to project to the flat top. (Please be sure you know how to do this prior to the day of your presentation)

If using the power point remote, attach the receiver into any of the USB ports available on the laptop.

Start the program; open the LifeTalks program using the power point software. Click “file”, click “open”, on this menu choose “HLCs power point” if doing the presentation in English, if in Spanish choose, “Presentacion de la clinica de LCCW”, click the “slide show from current slide: button at the bottom left of the screen or using the tool bar click “Slide Show”, then click “View Show”. You should have the first screen displayed on both the lap top and the flat screen.

Using the button located on the edge of the power point remote, you can scroll through the panels of the presentation. Pulling this button toward you will advance the screen and pushing it away will return to the previous screen. The larger button on the face of the remote is a laser pointer.

You are ready to give your presentation. (Remember to be interactive)

Closing the presentation:

The close of the presentation is a good time to generate referrals. It is also the part that makes many first time presenters a little nervous. You need to make the following points:

- Acknowledgement by the patients that chiropractic is beneficial
- Let them know that they have an opportunity to help others achieve greater health and wellness
- Thanks for their time and participation.
Example:

After the last screen is displayed ask, “How many of you feel that you have benefited from chiropractic?” (Most will raise their hands) Then ask, “how many of you can think of others who may also benefit from chiropractic?” (most will again raise their hands). Say, “We have an opportunity for you to share chiropractic with your friends and family. Because you attended this presentation, any body that you refer to the Health Center tonight/today, will receive half off of their initial exam.” (Pass around the clip board and some pens) “All you need to do is to write down the names of those whom you would like to refer and then you and your intern can work out how you will contact them and share this message.” Then say, “also for being here tonight, as a thank you to each of you we would like to give you a coupon for your next adjustment, free.” Hand out one coupon per patient. Again, thank everyone for coming and ask for questions.

After the presentation is over and patient questions have been handled, you will need to:
- Change the flat screen input source to PC1, do this by pressing the source button five times. The display at the upper left of the screen should briefly read PC1.
- Shut down the power point software.
- Shut down the computer (click on “start”, click on “shutdown”, on this screen click “OK”).
- Remove cable from lap top (do not remove from flat screen), wrap loose end between left speaker and flat screen, across top of flat screen, and down right side between flat screen and right speaker.
- Remove power point remote receiver from USB port and place receiver and remote in the power point remote case.
- Replace lap top and power cord in the lap top carrying case.
- Collect referral clip board and all referral sheets and remaining coupons.
- Return lap top # four and power point remote to the library. Return clip board, completed referral sheets, and remaining coupons to the office of the Dean of the Health Center.

OUTREACH

To participate in an Outreach Event you must have the 12 Point evaluation training in the Student Clinic (SC-2) class.  (Sample)

- Each intern must participate in 5 Outreach activities in order to graduate.
- Your mentor will help you prepare for self-procured events and to assist in the acquisition of events
- All events and activities must be approved through your Mentor and/or the Dean of the Health Center’s office.
- Prior to reaching out to an opportunity, you must receive approval from the Office of the Dean of the Health Center.
- All applications and fees associated with events must be submitted and approved prior to the event to the office of the Dean of the Health Center, including events and opportunities you set up yourself.
Interns will not be reimbursed for fees they have paid in advance.

Forms for completion of an outreach event are available on Canvas and must be signed off for approval by either your Practice Mentor or the office of the Dean of the Health Center before being turned in for credit.

Business Cards

An LCCW Health Center standard business card is established for the use of all interns in the LCCW Health Center. It may be ordered once the intern is drafted into a practice group (i.e. Week 5 of their Student Clinic 2 quarter). There are blank cards available at the front desk while interns wait for their cards to be shipped or as an alternative to personalized cards. These blank cards are available at no cost to the Interns. No other business card will be used. Cards can be ordered on the college website: http://lifewest.edu/about/monte-h-greenawalt-health-center/chiropractic-intern-business-card-order-form/.

All cards include your Mentor’s name as the licensed chiropractor, the College Health Center address, phone, and an appointment calendar and business hours.

The intern is identified as a chiropractic intern. Use of other licenses or certificates (i.e. massage therapy, acupuncture, athletic trainer MD, DO, etc.) cannot be used on the Health Center business card.

Please note that the cost for 1000 cards with shipping is a flat rate of $40. This will be deducted by the Life West Business Office from your financial aid.

Advertising

1. Interns are not allowed to advertise in any way other than one-on-one personal marketing and participation in approved marketing activities.
2. Any literature to be handed out by interns or posted online must first be approved by the office of Dean of the Health Center. All literature must include the LCCW Health Center name, address, and phone number, and the Mentor’s name and credentials. There can be no intern information or personal likeness on literature other than business cards. Please refer to the Life West branding guide for the correct colors and Health Center logo: http://lifewest.edu/brand/
3. Only approved business cards may be used.
4. Any marketing activity, either on or off campus, must be preauthorized by the interns’ Mentor and/or the office of Dean of the Health Center.
5. Interns cannot in any way promote themselves as “licensed.” This includes the terms doctor, Dr., D.C., doctor of chiropractic, chiropractor, etc. on business cards, phone, or cell phone answering systems, personal web pages, email addresses, social networking sites, or any other media. The acceptable terminology is Chiropractic Intern, Intern, Senior Intern, Student Intern, and Senior Chiropractic Intern
6. Interns cannot use other degrees, licenses, certifications, or credentials on any published materials in conjunction with the college, the Health Center, or the chiropractic internship. These include but are not limited to massage therapy, acupuncture, or nutrition credentials, personal training, or any other health care related field.
7. All advertising efforts must be approved by the office of the Dean of the Health Center before initiating the effort or event.
Social Media Advertising:

- The only social platforms that are approved to advertise on are Facebook, YouTube, Instagram, NextDoor, and Twitter.
- If the Intern would like to advertise online, they must be connected to the Life West Health Center social media platforms that are available.
- When advertising, they must tag the Life West Health Center Facebook page. The above advertising guidelines still apply.
- Intern profiles must be professional (i.e. no pictures of the Intern’s partying, no inappropriate conduct, appropriate attire in photos that the public and friends can see).
- The public may report inappropriate conduct to the state board if your profile isn’t professional and you identify yourself as a Chiropractor or Chiropractic Student. Please note: anything you post, tweet, or reference may be used against you in a legal case, so clean it up now! Always think: What would my new patient think of my profile? Will my prospective patients think of me as professional?
- Be cautious of what you like or share because it will show up on other’s newsfeeds.
- If you post a photo of your patient, a HIPAA release form must be in the patient’s profile.
- If you are adjusting in the photo, a licensed DC must be in the photo. This includes if you are out of the country and/or on mission trips.
- Don’t make any claims (i.e. ‘you will get better’)
- Follow the Advertising policy in the Health Center policy and procedures manual
- Tag or check in at the Life West Health Center Facebook Page
- Your biography must say you are an Intern at the Health Center
- Videos must be educational and you must cite all sources.
- Don’t allude to being a Chiropractor, you must introduce yourself as a Chiropractic Intern at the Life West Health Center

REPORT OF FINDINGS

Interns are required to give a Report of Findings to all patients following every physical examination including re-evaluations. The Report of Findings (ROF) is done following the CMR and/or prior to the first adjustment. Following the ROF, the patient signs the CMR Actions Page at the bottom in agreement with the proposed Case Management Plan. ROF’s are also scheduled on the MindBody calendar. The mentor has the ROF scripts in his or her office.
One-Time-Only (OTO) Care

One-Time-Only adjustment protocols include:

Before beginning the S.O.A.P. note, the intern is to take the patient file and visit slip to the faculty doctor for approval. The file will be reviewed and documented appropriately.

The patient file is to be reviewed noting the following:

- Restrictions and/or contraindications remarks of the Health Center faculty doctor(s)
- Review of the case history and examination findings
- Review of the S.O.A.P. notes of previous care
- Review of all laboratory and x-ray reports

The faculty needs to approve the OTO visit prior to the intern writing up the S.O.A.P. notes.

The substituting intern must follow the approved case management plan.

The intern is to line through/cross out the name of the intern of record on the top of the visit slip and write their name and doc code. The faculty will initial the change.

No patient may be seen more than three (3) times in a quarter by an intern other than the intern of record unless otherwise approved by the mentor and documented in the faculty notes.

No OTO’s will be allowed on files that are past due for re-evaluation except for cases that fall under ‘acute care’ protocol guidelines.

No credit for OTO’s on student category, student courtesy patients, or outpatient courtesy. Credit will only be given for OTO’s on regular outpatients.

EXCEPTION: SC-2 Students will be allowed a maximum of 3 student OTO during the quarter. Note: One OTO per patient. One OTO per patient ONLY. Three OTO per intern. Faculty to write onto the Visit Slip ‘SC-2 Approved OTO’.

No OTO’s are allowed under vacation relief protocol.

There are no OTO’s allowed on new patients who have not had their initial CMR completed yet.

Vacation/Vacation Relief Process

All interns must discuss their vacation with their mentor in advance. This includes any time taken during academic breaks.

The intern is responsible to:

1. Make sure the re-eval dates are current through the vacation period. Credit may not be given to the relief intern if the file is not current.
2. Give all patients the dates that the intern of record will be gone.
Give all patients the names and contact information of other intern(s) who will care for them while their intern of record is gone.

Make sure the other interns are available. Give them the names of the patients.

Discuss any special considerations of the patients’ care with the other intern(s)

Appointments must be made and verified with the substitute intern(s).

Mentor writes the substitute intern’s name and time they will cover on the Faculty Notes page.

No credit for OTO’s will be given under vacation relief protocol.

Both interns need to be present when assigning vacation relief duty.

Patient must be assigned to a vacation relief intern. If this is not done, adjustment credit will be taken from the intern of record when they return from vacation and the patient may be transferred to another intern.

**Adjusting**

Qualified interns are allowed to adjust in the Health Center under Health Center faculty supervision and under the specific guidelines as described in the Health Center Policies and Procedures Manual. The college will actively pursue sanctions against interns/students found to be adjusting outside the Health Center, or without proper supervision.

**WRITING IN THE PATIENT FILE**

**S.O.A.P. NOTE FORMAT GUIDELINES**

Required for all LCCW Health Center (HC) Patient Soap notes

**SUBJECTIVE:**

HC: What was your response to last visit?

Put pt answers in quotes. If pt is NOT symptomatic –then home care and lifestyle should be discussed and documented in the Plan (P) section of the SOAP note.

- The response to last visit must include more than “good,” “great,” etc.
- How long was pain absent? What brought the pain back? Is it the same pain?
- Pattern? Did the pain shift? Is the intensity less? Follow up on activities of daily living and recommendations given last visit (level of compliance) such as exercises, icing, use of a cervical pillow, etc.
- If there is pain in any area or areas, then include the Visual Analog Scale (VAS) for each area. If the patient has stiffness and/or tightness: No VAS for “stiffness”, “tension”, “tightness” is needed.
- OPQRST is not necessary for each visit, except when there has been an exacerbation of a complaint already addressed in the history and exam.
- Example: “Neck pain from last visit subsided until today, now it is 2/10. I slept better and had more motion in my neck. Today I have pain on the upper right side of my mid-back, 3/10, I’ve been walking 20 min a day as you suggested”.

Health Center Manual: Section Two  65
OBJECTIVE:

■ Address the whole spine. Include all significant (+) findings as well as (-) findings that are appropriate.
■ For every segment, including extremities, that you are going to adjust, you need three findings from three different exams. For example, ROM, if decreased in three ranges, counts as one criterion only. Use the word decreased, restricted or a down arrow to describe ROM findings. Be specific to level and direction.
  ■ Example: C3: Decreased lateral flexion on right, decreased right rotation, decreased flexion: This is one finding from the patient’s segmental ROM exam. You now need two other exam findings to justify the adjustment at C3.
■ Include “global, or regional” findings, which may be present in addition to specific level findings. Example: Static palp -T4-T8 muscle spasm
■ Example: “Visual: High R ear, Shldr, Ilium, Static Palp: Edema and T and T fibers Cerv 5-7, Thor 4..Motion Palp: Decreased R Lat Flex and Rt Rot Cerv 5, Decreased Lt rotation, RLF T4, Decreased LLF, Rt Rot L5”

ASSESSMENT:

■ Today’s subjective and objective findings should be consistent with the assessment.
■ Use minimal, slight, moderate, severe based on the VAS score to document severity of symptoms. You do not need to mention chronicity.
■ Structural findings, such as DJD, DDD, do not have to be listed.
■ Example: VSC cervical spine, minimal neck pn, VSC Thoracic spine, slight upper back pn

To be used in Assessment section of SOAP if symptoms of pain are present

<table>
<thead>
<tr>
<th>Phase of Injury</th>
<th>Onset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>0-72 hours</td>
</tr>
<tr>
<td>Subacute</td>
<td>72 hrs-2 weeks</td>
</tr>
<tr>
<td>Chronic</td>
<td>2 weeks and beyond</td>
</tr>
</tbody>
</table>

■ Frequency (Timing – note that these are all “during waking hours”)
■ Constant: Occurring approximately 90-100% of the time
■ Frequent: Occurring approximately 75% of the time.
■ Intermittent: Occurring approximately 50% of the time.
■ Occasional: Occurring approximately 25% of the time.
■ Less than Occasional/Seldom/Infrequent (LCCW terms): Occurring <10% of the time.

Intensity (Severity)

■ Minimal or mild: (LCCW VAS of 1-2) A pain that would constitute an annoyance, but would cause no handicap in the performance of activity.
■ Slight: (LCCW VAS of 3-4) A pain that could be tolerated, but would cause some handicap in the performance of the activity precipitating the pain.
TABLE OF CONTENTS

- **Moderate**: (LCCW VAS 5-7) A pain that could be tolerated, but would cause a marked handicap in the performance of the activity precipitating the pain.
- **Severe**: (LCCW VAS 8-10) A pain that would preclude the activity precipitating the pain.

**PLAN:**
- Technique
- Listing
- Patient Position (supine, prone, knee chest, cervical chair, etc.)
- Doctor set up (knife edge, single hand, double thenar, etc.)
- If PT is going to be used, write what modality and the area it is used on.
- List patient recommendations/homecare if discussed on this visit.
- HC: It is recommended that you have the next scheduled visit already set up and you may note it here as well as on the visit slip.
- OL: You may list the recommended next visit either to be done in Open Lab or with student pt’s regular intern.
- Example: DIV C5 PR seated, DIV T4 PLI-t single hand prone. Next visit in one week. Continue 20 min daily walk.

**POST CHECKS:**
Address what is appropriate based on what you used to determine the subluxation in the first place.

Example: Increased Cervical ROM, Legs even, Muscle tone-same.

**ABBREVIATIONS FOR HEALTH CENTER FILES**

Writing in the Patient File Abbreviations for Health Center Files

The abbreviations listed below can be used to shorten note-taking in the patient file. Any other personal abbreviations are not acceptable.

- AAA Abdominal Aortic Aneurysm
- abd abduction
- abn abnormal
- AC jt acromioclavicular joint
- add adduction
- adj adjustment
- ADLs Activities of Daily Living
- AHC Anterior head carriage
- ALLI Anatomical Leg Length Inequality test
- am morning
- ant anterior
- AP anterior to posterior
- AROM Active range of motion
- ASIS anterior superior iliac spine
- B/g beginning/began
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blk</td>
<td>blocks- used with SOT or CBP</td>
</tr>
<tr>
<td>BL</td>
<td>bilateral</td>
</tr>
<tr>
<td>CC</td>
<td>chief complaint</td>
</tr>
<tr>
<td>C/T</td>
<td>cervicothoracic</td>
</tr>
<tr>
<td>CVA</td>
<td>cardiovascular accident</td>
</tr>
<tr>
<td>CVJ</td>
<td>costovertebral joint</td>
</tr>
<tr>
<td>DJD</td>
<td>degenerative joint disease</td>
</tr>
<tr>
<td>E</td>
<td>edema</td>
</tr>
<tr>
<td>EENT</td>
<td>eyes, ears, nose, throat</td>
</tr>
<tr>
<td>ET</td>
<td>elastic taping</td>
</tr>
<tr>
<td>ext</td>
<td>extension</td>
</tr>
<tr>
<td>F</td>
<td>fixation</td>
</tr>
<tr>
<td>Flx</td>
<td>flexion</td>
</tr>
<tr>
<td>FM</td>
<td>Functional Medicine</td>
</tr>
<tr>
<td>FS</td>
<td>full spine</td>
</tr>
<tr>
<td>FT</td>
<td>Functional Training/Rehab</td>
</tr>
<tr>
<td>F/U</td>
<td>follow-up</td>
</tr>
<tr>
<td>Fx</td>
<td>fracture</td>
</tr>
<tr>
<td>GI</td>
<td>gastrointestinal</td>
</tr>
<tr>
<td>GU</td>
<td>genitourinary</td>
</tr>
<tr>
<td>GYN</td>
<td>gynecological</td>
</tr>
<tr>
<td>H</td>
<td>hypertonic muscles</td>
</tr>
<tr>
<td>HA</td>
<td>headache</td>
</tr>
<tr>
<td>HBP/HTN</td>
<td>high blood pressure/hypertension</td>
</tr>
<tr>
<td>HPI</td>
<td>History of Presenting Illness</td>
</tr>
<tr>
<td>Hx</td>
<td>history</td>
</tr>
<tr>
<td>IVD</td>
<td>intervertebral disc</td>
</tr>
<tr>
<td>KT</td>
<td>kinesiotape</td>
</tr>
<tr>
<td>Lt</td>
<td>left</td>
</tr>
<tr>
<td>Lab</td>
<td>laboratory</td>
</tr>
<tr>
<td>Lat</td>
<td>lateral</td>
</tr>
<tr>
<td>LB</td>
<td>low back</td>
</tr>
<tr>
<td>LBP</td>
<td>low back pain</td>
</tr>
<tr>
<td>LE</td>
<td>lower extremity</td>
</tr>
<tr>
<td>lig</td>
<td>ligament</td>
</tr>
<tr>
<td>LLF</td>
<td>left lateral flexion</td>
</tr>
<tr>
<td>LLLT</td>
<td>low level laser therapy</td>
</tr>
<tr>
<td>L/S, L-S</td>
<td>lumbosacral</td>
</tr>
<tr>
<td>MFR</td>
<td>myofascial release</td>
</tr>
<tr>
<td>MI</td>
<td>myocardial infarction</td>
</tr>
<tr>
<td>mm</td>
<td>muscles</td>
</tr>
<tr>
<td>MP</td>
<td>motion palpation</td>
</tr>
<tr>
<td>MRI</td>
<td>magnetic resonance imaging</td>
</tr>
<tr>
<td>MVA</td>
<td>motor vehicle accident</td>
</tr>
<tr>
<td>NAD</td>
<td>no abnormality detected</td>
</tr>
<tr>
<td>-</td>
<td>Negative</td>
</tr>
<tr>
<td>Neg</td>
<td>negative</td>
</tr>
<tr>
<td>O/U</td>
<td>overuse</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>OV</td>
<td>office visit</td>
</tr>
<tr>
<td>P-A</td>
<td>posterior to anterior</td>
</tr>
<tr>
<td>PERRLA</td>
<td>pupils equal round regular react to light and accommodation</td>
</tr>
<tr>
<td>PI</td>
<td>personal injury</td>
</tr>
<tr>
<td>palp</td>
<td>palpation</td>
</tr>
<tr>
<td>PMS</td>
<td>pre-menstrual syndrome</td>
</tr>
<tr>
<td>Pn</td>
<td>pain</td>
</tr>
<tr>
<td>Pos or +</td>
<td>positive</td>
</tr>
<tr>
<td>prn</td>
<td>as needed</td>
</tr>
<tr>
<td>PSIS</td>
<td>posterior superior iliac spine</td>
</tr>
<tr>
<td>Pt</td>
<td>patient</td>
</tr>
<tr>
<td>PT</td>
<td>physical therapy</td>
</tr>
<tr>
<td>q.</td>
<td>every</td>
</tr>
<tr>
<td>q.d.</td>
<td>once a day</td>
</tr>
<tr>
<td>b.i.d.</td>
<td>twice a day</td>
</tr>
<tr>
<td>t.i.d.</td>
<td>three times a day</td>
</tr>
<tr>
<td>Rt</td>
<td>right</td>
</tr>
<tr>
<td>R</td>
<td>rubor/redness</td>
</tr>
<tr>
<td>Rest</td>
<td>Restriction</td>
</tr>
<tr>
<td>RA</td>
<td>rheumatoid arthritis</td>
</tr>
<tr>
<td>RLF</td>
<td>right lateral flexion</td>
</tr>
<tr>
<td>ROM</td>
<td>range of motion</td>
</tr>
<tr>
<td>R/O</td>
<td>rule out</td>
</tr>
<tr>
<td>ROS</td>
<td>review of systems</td>
</tr>
<tr>
<td>ROT</td>
<td>rotation</td>
</tr>
<tr>
<td>RSI</td>
<td>repetitive stress injury</td>
</tr>
<tr>
<td>RT</td>
<td>Rocktape</td>
</tr>
<tr>
<td>S</td>
<td>spasm</td>
</tr>
<tr>
<td>SI</td>
<td>sacroiliac</td>
</tr>
<tr>
<td>SCM</td>
<td>sternocleidomastoid</td>
</tr>
<tr>
<td>SLR</td>
<td>straight leg raise</td>
</tr>
<tr>
<td>SMT</td>
<td>spinal manipulative therapy</td>
</tr>
<tr>
<td>SP</td>
<td>spinous process</td>
</tr>
<tr>
<td>Sx</td>
<td>symptoms</td>
</tr>
<tr>
<td>TT</td>
<td>taut and tender</td>
</tr>
<tr>
<td>TENS</td>
<td>transcutaneous electrical nerve stimulation</td>
</tr>
<tr>
<td>TFM</td>
<td>transverse friction massage</td>
</tr>
<tr>
<td>TMJ</td>
<td>temporo-mandibular joint</td>
</tr>
<tr>
<td>TMD</td>
<td>temporo-mandibular disorder</td>
</tr>
<tr>
<td>TOS</td>
<td>thoracic outlet syndrome</td>
</tr>
<tr>
<td>tp</td>
<td>transverse process</td>
</tr>
<tr>
<td>TP</td>
<td>Trigger Point</td>
</tr>
<tr>
<td>trap</td>
<td>trapezius</td>
</tr>
<tr>
<td>TTT</td>
<td>taut, tender, TP</td>
</tr>
<tr>
<td>Tx</td>
<td>treatment</td>
</tr>
<tr>
<td>UA</td>
<td>urinalysis</td>
</tr>
<tr>
<td>UE</td>
<td>upper extremity</td>
</tr>
<tr>
<td>URI</td>
<td>upper respiratory infection</td>
</tr>
<tr>
<td>US</td>
<td>ultrasound</td>
</tr>
<tr>
<td>UTI</td>
<td>urinary tract infection</td>
</tr>
</tbody>
</table>
TABLE OF CONTENTS

VAS visual analog scale
VSC vertebral subluxation complex/subluxation
WB weight bearing
wk week
/w per week
w/ with
c without
WNL within normal limits
ǭ every
ā before_
P after

Technique Abbreviations:

ACT Activator
ADVO Advanced Orthogonal
BLk Blocks (used according to listing)
BLR Blair
CBP Chiropractic Biophysics
DIV Diversified
DROP Drop Table
EPIC Evolutionary Percussion Instrument Correction
GON Gonstead
Non-core Techniques
NUC NUCCA National Upper Cervical Chiropractic Association
SOT Sacral Occipital Technique
TOG Toggle

Additional symbols:

< Less than
> Greater than
→ causing, leading to, producing
↑ increased, increasing
↓ decreased, decreasing
≈ Approximately
HEALTH CENTER MANUAL

SECTION 3

HEALTH CENTER SUPPLEMENTAL INFORMATION

The Administration of the College/Health Center reserves the right to add, delete, or modify the Health Center’s policies and procedures as needed.
TABLE OF CONTENTS

PUBLIC HEALTH RECOMMENDATIONS

In an effort to keep Staph aureus/MRSA out of the Health Center, the following procedures apply. If a patient, intern, faculty or staff has any soft tissue infection, cut or scrape that is oozing, hot to the touch, or swelling then the infection is spreading. The person needs to go to urgent care. It is the intern’s responsibility to wipe and disinfect any areas that the patient may have exposed to a virus or bacteria. If the cut is bandaged then the risk is minimized.

Interns are not tested for TB before they enter their internship at the Health Center. If a patient is coughing up sputum with blood, they need to head to an Emergency Department. This is not a case that can be seen or treated in the Life West Health Center. This may be a sign or presenting symptom of TB/Klebsiealla pneumoniae, or lung cancer.

Anyone (patients, interns, faculty or staff) that has a fever at 100 or higher should stay home particularly if it’s accompanied by an upper respiratory disease

Interns must always be vigilant for signs and symptoms of the following:
- Influenza - abrupt onset of fever, lethargy, difficulty eating, etc.
- Any vaccine preventable disease: mumps/measles/rubella/chickenpox - all appear as a rash (rubella is a swollen throat).
- Meningitis - very high fever, stiff neck where patient can barely turn their head, photosensitivity, headache, nausea, lethargy.

CRIME PREVENTION

The Life West Office of Campus Enhancement has always taken the position that it is best to inform students and employees of unsafe practices and conditions. Each September, campus crime statistics are posted on the College’s website and are available to the College community and to prospective students. The theft of any item, no matter how insignificant it may seem, should be reported to the Student Life Office immediately.

Please see the assistant to the Dean of the Health Center or Student Life to obtain and fill out an incident report when a theft occurs. Please make sure that you lock your vehicle, close your windows, and keep valuables out of sight as a preventative measure.

Emergency Procedures

In the event an emergency arises in the Health Center (i.e. heart attack, seizure, personal injury, etc.), it is mandatory that the following procedure be followed:
- The intern is to stay with the patient
- A Health Center faculty doctor will take appropriate first aid measures
- A Health Center faculty doctor will authorize a call to 911, if necessary

Standard first aid kits are placed at key Health Center locations. Become familiar with these locations. There is an AED (Automated External Defibrillator) located behind the front desk.

Once the immediate crisis has passed, write a detailed report of the incident as it occurred in the S.O.A.P. notes, complete an incident Report form and have a Health Center faculty doctor initial both. Include these forms in the patient’s file and forward a copy to the Dean, Health Center. Complete any other necessary forms so the patient may be referred properly, if needed.
In accordance with the college’s Injury and Illness Prevention Program, all non-ambulatory patients must be seen downstairs in the Health Center. Practice Mentors will come downstairs to observe patient care. The only exception to this is patients seen in the Imaging Department. Do NOT use the elevator in the event of an emergency.

**Personal Property**

Life Chiropractic College West is not responsible for the personal property of the students (e.g., books, supplies, laptops, equipment and clothing). Students are encouraged to place their names & student ID numbers on all items of value and record and secure equipment serial numbers. Students should review their personal property/homeowners/renters and automobile comprehensive insurance policies to determine whether valuable equipment (such as laptops, diagnostic or adjusting equipment) would be covered in the event of theft or loss.

**Campus Law Enforcement**

The Life West Office of Campus Enhancement is not a law enforcement agency, and therefore, does not make arrests. While each student, employee and visitor is subject to the lawful request and direction of a campus security officer, arrests, if necessary, are affected through the local jurisdiction by use of arrest warrants.

**Equipment**

Consideration of the next intern’s use of the equipment is necessary.

- Immediately report any broken or damaged equipment to the Health Center faculty. Work order forms are available in all faculty offices and should be submitted to the Front Desk staff. Be as specific as possible about the problem and the location (room or cubicle number, etc).
- All rooms are to be left in a neat and orderly fashion
- Activator tables are to be returned to their horizontal position.
- Always return special equipment, such as SOT blocks and physical therapy equipment, to their proper storage area.
- Watch carefully for hands, feet, jewelry, or other items that might get caught in moving equipment.
- Use caution when children are in the room. Keep potentially dangerous equipment out of the reach of children, and keep children away from all equipment for their safety.
- Clean the face area of each table after each use with sanitizing wipes provided in each room.
ABUSE REPORTING

Child, Elder, or Dependent Adult Abuse - Reporting is Mandatory

When an intern suspects child (under 18 years), elder (65+ years), or dependent adult (18-64) abuse, the intern is to tell the patient (and caregiver) that the intern needs help with patient assessment. The intern is to go to his or her mentor.

The Mentor will:

- Meet the patient
- Examine and ask questions necessary (caregiver should remain in the room)
- Decide if any x-rays are necessary
- Decide if the case needs to be reported to the appropriate authorities If the case needs to be reported, follow these steps:
  - Notify the Dean of the Health Center
  - Phone the appropriate agency immediately
  - Write a report within 24 hours: Reporting of suspected child, elder, or dependent adult abuse is the legal responsibility of all health care professionals and must be done within 24 hours of the observation of evidence. All full time Health Center Faculty are appointed this responsibility in the Health Center and will report and document the suspicion within 24 hours to:

  Hayward Police Department 300 West Winton Avenue Hayward, CA 94544
  (510) 293-7125 or (510) 293-7048
  Alameda County Emergency Response Unit 24 hour hotline
  (510) 259-1800
  or
  Alameda County Child Abuse Prevention Council
  PO Box 70803
  Oakland, CA 94612
  To report elder or dependent adult abuse: Alameda County Adult Protective Services 24 hour hotline
  (510) 577-1900
  If domestic violence/spousal abuse is suspected, the following hotlines are available to the patient:
  S.A.V.E. (Safe Alternatives to Violent Environments) Hotline: (510) 794-6055 - Alameda County
  Call the National Domestic Violence Hotline: 1 800 799-7233 or 1 800 787-3224
  Call 911 if you are in immediate danger.
MEDICARE GUIDELINES

Federal Medicare guidelines require that the chiropractor is limited to the use of specific identifying codes, procedures, and terminology in order to justify and expedite reimbursement for chiropractic services. When completing the diagnosis for a Medicare patient, the following guidelines should be used:

The patient must have significant health problems in the form of neuro-musculoskeletal condition(s) necessitating care, and the adjustment rendered must have a direct therapeutic relationship to the patient’s condition.

Medicare coverage is specifically limited to the identification and correction of subluxation, by means of adjustment to the spine. X-rays are not covered, nor are such services as physical therapy or supports. (See “Medicare Patient” for additional information).

Patient’s file should be blue.

Children

Children of patients are to be supervised by their parent(s) or guardian(s) at all times.

Children of interns are not allowed in the Health Center while their parents are performing Health Center business of any kind. This includes patient care, CMRs and file work.

Communication Methods

CANVAS - Please enroll and visit the Intern Canvas page at https://lifewest.instructure.com/enroll/7MYEHL. You will be responsible for this information.

Email

Life West Student Email - first initial + last name@college.lifewest.edu. Important updates will be emailed to you, so keep checking your email.

The Health Center uses the intern’s college email for dissemination of all updates and notifications. This may include changes to Health Center policies and procedures.

The LCCW Health Center internal communications are accomplished via text messaging through the intern’s personal cell phone. It is required that all interns provide their cell phone account information (this is usually collected during the Student Clinic 1 class).

After a patient checks in at the front desk, the intern will be informed via text message that the patient has arrived. If you do not respond, your mentor will be contacted. Administrative offices in the Health Center also use this system to contact interns.

CALENDAR

All student and outpatient exams, x-ray appointments, office visits, CMR’s and Report of Findings should be scheduled on the Mind Body calendar under your name. To access, go to www.MindBodyonline.com, and under Find Your Site, search for Life Chiropractic College West and log in. You may also use the Mindbody EXPRESS App.
VISIT SLIP PROCEDURES AND COMPUTER FUNCTIONS

The LCCW Health Center maintains the financial accounting and patient management functions by computer. The basic functions of the computer are as follows:

Assignment of patient accounting and file number and all appropriate personal information is entered into the system to accommodate appropriate legal aspects, insurance billing, and patient management.

The system’s ability to handle this information is dependent upon the accurate completion and handling of the Patient Visit Slip. It is the intern’s responsibility to see that documentation is completed properly. The Visit Slips require authorized Health Center Faculty signatures to be approved for computer entry.

All patient financial accounting and record keeping is documented via the intern Doc Code. This code must be clearly printed on all credit or Patient Visit slips. Interns are responsible for keeping their (pink) copy of the visit slip for credit verification.

No adjustment credit is given if the visit slip is NOT turned in that day, or is turned in after 6:45 on Monday and Wednesday; after 7:45 pm Tuesday and Thursday or after 5:45 PM on Fridays! Only the Dean of the Health Center can authorize any changes to the visit slip once it has been turned in.

Supplemental instruction concerning the Health Center computer system is provided as new programs are instituted or upgraded or deleted.

COMMUNITY BENEFITS PROGRAM PROCEDURES

Since our mission at Life Chiropractic College West is to give, to love, and to serve, participation in the Community Benefits Program is available to those patients that qualify financially. The patient will count as one courtesy patient. All other policies and procedures of the Life West Health Center apply.

Community Benefits Patient Procedures

If the person is living in any kind of shelter, a letter from the Lead Counselor or House Manager of that shelter on the shelter’s letterhead is all that is required to begin care in the community benefits program.

If the patient needs to be qualified for community benefits care based on financial need, our Customer Service Manager should be contacted to determine what documents they need to bring in to qualify. The Health Center has the right to refuse care to patients who do not bring in the required documents. Under no circumstances is the intern allowed to intervene in the qualification process or discuss the financial status of the patient.

So that we can best serve the community and patients who have a financial and health care crisis, Community Benefits status is given for 180 days. The patient is required to be an active participant in their care which speeds up recovery and healing. We are expecting that the patient’s health, function, and vitality will improve tremendously after 6 months of consistent care. At this point, the patient will be expected to pay regular prices if they wish to continue care.
HIPAA

Health Insurance Portability and Accountability Act - HIPAA

HIPAA is a program designed by the federal government to ensure that patients' health records are kept confidential. It protects patients' privacy through: Visual privacy, Auditory privacy, and prevents unauthorized access.

Privacy Officer: Compliance Officer; Security Officer: Dean of the Health Center

How is protection achieved?

- Training of staff/faculty/interns
- All staff/faculty/interns sign confidentiality agreements
- Physical security measures (such as: plexiglas in Records Room, Records Room door being locked.
- Check-out line, log-in codes for computers, and password protected screensavers on all computers containing patient information.)
- Confidentiality agreements with all business associates
- Privacy Notice for all patients and Acknowledgment of Receipt of Privacy Notice
- Student Authorizations for “open room” adjusting and exam courses
- Patients have the right to request Alternative Communications, Restriction of Health Information, Complaint Forms, Request for Records, and Accounting of Disclosures. All forms are forwarded to the privacy officer (Compliance Officer).
- Any employee/faculty/intern who is found to breach patient confidentiality will be sent to the privacy officer for sanctions.
- Intern Sanctions for HIPAA Breaches;
  - 1st Offense: 3 page paper on HIPAA
  - 2nd Offense: 2 week suspension from the Health Center
  - Additional Offenses: Health Center Suspension up to Expulsion from the college depending on the severity of the breach(es)

The most common causes for breach of patient confidentiality can be prevented by following these rules:

- Keep control of patient files/x-rays at all times: all files/x-rays must be returned at the end of the night; files/x-rays cannot be left unattended; files/x-rays cannot be left with another intern; files/x-rays must be taken into the bathroom stalls with the intern instead of leaving them on the sink; no patient information can be removed from the HC for any purpose (e.g. doing narratives at home); when typing narratives at the HC if you copy to USB drive do not include patient's name. Any USB or cloud drive with any narrative, even if it doesn’t have the patient’s name, should be password protected.
- Do not discuss your patient’s condition out loud while in the waiting room, check-out line, or walking through the halls. Only discuss patient information in the room with the patient or in a room with your mentor. When talking on the phone with your patient, avoid discussing their condition as others might overhear.
Paperwork that contains the patient’s name cannot be discarded into trash or recycling, it must be shredded. There are shredding receptacles throughout the Health Center. If you send information to a printer, you must make sure that you pick up all the pages. If there is a problem with the printer, let your mentor or the records room staff know.

CAMPUS FACULTY CONSULTATION GUIDELINES FOR HIPAA COMPLIANCE

This form must be completed before a non-Health Center faculty doctor may review a patient file and/or make recommendations for care.

1. Individuals requesting consultation (intern or Mentor) must fill out all the information in the right hand corner of the form and under Purpose of Consultation, Chief Complaint, Pertinent History, Relevant Physical Exam and other related findings.

2. The individual seeking the consultation must sign under Requested By in order for this request to be considered and the request has been reviewed and signed by the intern’s Mentor.

3. Once the consultation request has been reviewed and signed it must be placed in the patient's file behind the Faculty Notes page, and be noted in the Faculty Notes. This must be done prior to the scheduling of the consultation. The patient file and the Campus Faculty Consultation form may not be removed from the Health Center.

4. The requesting individual, having followed the above steps, may then set an appointment with the consultant. All appointments must be held within the Health Center.

5. The consultant must write his/her comments and recommendations on the back of the form signing his/her name, credentials, and the date.

6. The intern’s Mentor then reviews the consultation, and the intern will discuss any CMR changes to treatment with Mentor doctor.

7. The results of any consultation must not be discussed with the patient prior to the review by the intern’s Mentor and modification of the care plan in CMR.

PERSONAL APPEARANCE AND DRESS CODE

All interns are expected to be in professional attire while in the Health Center for attending to any Health Center business (i.e. seeing patients, CMRs, faculty advisor meetings, making appointments, checking out files, etc.).

Your appearance communicates how you feel about our profession and our institution, and should inspire confidence, and communicate respect to patients and their families. Please consider the patient’s point of view regarding intern’s dress and appearance. The general public expects doctors to have a clean, neat appearance and professional dress.

The following dress code will be strictly enforced. The penalties for an appearance or dress code violations are as follows: Return to Section 1 table

- 1st infraction: The intern will be sent home to change and will lose two outpatient adjusting credits
- 2nd infraction: The intern will be sent home to change and will lose five outpatient adjusting credits
- 3rd infraction: The intern will be sent home and will be immediately suspended from the Health Center for one week.
The intern involved will be not allowed to participate in patient care or any other patient interaction until s/he meets the appearance and dress code.

All Health Center faculty and staff have the authority to enforce the appearance and dress code.

**APPEARANCE/GROOMING**

- Professional appearance includes regular bathing and clean short fingernails.
- Hair: hair shall be clean and neat. Extreme hair colors, styles, and hair ornaments should not be worn in a professional health care setting. Long hair should be tied back or worn up so that it does not touch the patient.
- Men should be clean-shaven or facial hair neatly trimmed daily.
- Cosmetics: Cosmetics if worn should be used in moderation
- Perfume/Cologne/Fragrance: Perfumes, colognes, or heavy fragrances must not be worn, as many patients and staff members are sensitive to scents and odors.
- Jewelry: Jewelry should be conservative in style and short enough not to dangle in patients or become tangled in equipment. There should be no visible body piercing except for simple earrings.
- Tattoos: Tattoos should be covered at all times.
- Undergarments: Undergarments must be worn under clothing and should not be exposed. Interns must not wear clothing which may reveal undergarments while performing examinations or providing care.

**DRESS CODE FOR FEMALE INTERNS INCLUDES:**

Female interns will wear clean and pressed neutral colored dress slacks and blouses. Necklines must be modest and can be no lower than the joint of the manubrium and the body of the sternum. No sleeveless tops are allowed. Bras must be worn. Socks or stockings and clean dress shoes with closed toes, closed sides, and closed backs must be worn.

**DRESS CODE FOR MALE INTERNS INCLUDES:**

Male interns will wear clean and neatly pressed dress shirts and neatly pressed dress slacks in neutral colors. A tie must be worn. Socks must be worn (no white or athletic socks). Clean brown or black dress shoes with closed toes and backs, or brown or black dress boots are acceptable. Facial hair must be clean and trimmed.

**TOBACCO, DRUG AND ALCOHOL USE**

The use of tobacco products (including smokeless) are not allowed on the campus near any of the Health Center doors. Since these products leave a residual smell on the breath and the clothing, interns who wish to smoke should use a breath freshener before resuming patient care of any kind. The residual smell is both offensive and allergenic for many patients. Interns are absolutely prohibited from the use of alcohol or recreational drugs prior to engaging in any health center activities whether on or off campus (such as an outreach opportunity). Refer to the Student Manual for a more complete explanation of the LCCW related policy and procedures.

As a student intern you should be aware of any adverse reaction and side effects if taking...
certain prescription medications or recreational habits that may impair the intern’s cognitive and/or psychomotor ability to provide quality patient care.

HEALTH CENTER ID

OSHA requires that intern’s Health Center ID must be worn and clearly visible at all times within the Health Center. The only acceptable ID is official LW-HC ID badges that have been produced in the Student Life Office. Business cards may not be used as ID. ID cards should be used on exam room doors or curtains during your patient encounter. Note: If/when you leave the room the ID should come with you. Your ID is not to be used to save a room.

ID badges must be worn on your top and placed well above the waist line. NO exceptions. Infractions of the Health Center ID policy will fall under the same penalty as violations to dress code and appearance policy.

OSHA STANDARDS

Life Chiropractic College West Health Center adheres to all OSHA standards recommended by the State of California. Exact Policies and Procedures of OSHA can be found in the office of the Dean of the Health Center.

PRECEPTORSHIP PROGRAM

It is the intent of the program to offer senior interns, who have completed all LCCW graduation requirements, a wider and more diverse clinical experience. To that end, the college has established a Preceptorship Program available for periods of three (3) months, on a voluntary basis, with the following conditions:

- The intern must have completed all clinical requirements for graduation with the exception of the hours requirement which may be partially offset at the preceptorship location.
- The intern must be registered for Clinic 4 and be in the last senior term (12th quarter or its equivalent extended/special schedule quarter).
- The intern must have passed the I.C.E. (Intern Competency Exam)
- The intern must, by performance in the Health Center, have shown good character, have attained an acceptable degree of clinical proficiency, and have demonstrated a spirit of cooperation and willingness to learn.
- The intern must be approved for the Program by the Dean of the Health Center. The preceptorship must not interfere with the intern’s didactic studies nor delay admission as a candidate for examination by their chosen State Board of Examiners.
- The number of hours served in the preceptorship may be credited as Health Center hours, but the hours credited may not be in excess of 35 hours weekly as prescribed by the California Board of Chiropractic Examiners.
- Only interns enrolled in the Preceptorship Program may check out of the Health Center prior to week 8 of their last quarter enrolled at LCCW.
- Program is also available to graduates. (Return to Section1)
RECOGNITION OF INTERNS

- **Interns of the Month:** Each month, one intern from each HC practice will be recognized as Intern of the Month. This intern is generally the highest producing intern from the group during the month, but also requires the recommendation of the mentor.

- **Intern of the Quarter:** The highest producing intern of the Health Center each quarter will be recognized as Intern of the Quarter upon the recommendation of his/her mentor. This intern is awarded a certificate during the quarterly Health Center Recognition Seminar.

- **Honors Program:** In this program, interns are recognized for their performance based on patient visit numbers in excess of the minimal requirements while remaining in good standing in the Health Center and campus environments. (Good standing means that the intern has not had any disciplinary action, is not on a contract with the Office of Academic Affairs (OAA) or the Clinical Standards Committee (CSC), and has maintained pace of no more than 6 quarters of clinic to complete his or her graduation requirements.

- Recognition will be awarded to interns who achieve outpatient visits of 275, 300, 350, and 400.

- Once an intern has achieved 75 student adjustments and 250 outpatient adjustments, all student adjustments over 50 will be populated towards the Honors requirements.

- For interns beginning Clinic I in Fall 2015 or later, once an intern has achieved 75 courtesy patient adjustments, all courtesy patient adjustments over 50 will be populated towards the Honors requirements.

- These student (and courtesy patient) adjustments will NOT be counted towards the outpatient graduation requirement.

**RECOGNITION WILL BE AWARDED AS FOLLOWS:**

<table>
<thead>
<tr>
<th></th>
<th>275</th>
<th>300</th>
<th>350</th>
<th>400</th>
<th>&gt;400</th>
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<tbody>
<tr>
<td>Honor pin</td>
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<td>Honor pin</td>
<td>Honor pin</td>
<td>Honor pin</td>
<td>Honor pin</td>
</tr>
<tr>
<td>Wall and TV recognition</td>
<td>Wall and TV recognition</td>
<td>Wall and TV recognition</td>
<td>Wall and TV recognition</td>
<td>Wall and TV recognition</td>
<td></td>
</tr>
<tr>
<td>Honorable Mention at Graduation</td>
<td>Bronze Honors Medal at Graduation</td>
<td>10% discount at the Bookstore (does not include food/drinks)</td>
<td>10% discount at the Bookstore (does not include food/drinks)</td>
<td>10% discount at the Bookstore (does not include food/drinks)</td>
<td></td>
</tr>
<tr>
<td>Silver Honors Medal at Graduation</td>
<td>First LCCW Re-Licensure seminar free (only applies to seminars sponsored only by LCCW)</td>
<td>First LCCW Re-Licensure seminar free (only applies to seminars sponsored only by LCCW)</td>
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<tr>
<td>Framed LCCW Diploma (from the frames available at the Bookstore)</td>
<td>Framed LCCW Diploma (from the frames available at the Bookstore)</td>
<td>Framed LCCW Diploma (from the frames available at the Bookstore)</td>
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<tr>
<td>Gold Honors Medal at Graduation</td>
<td>Platinum Honors Medal at Graduation</td>
<td>Platinum Honors Medal at Graduation</td>
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</table>

**CLINICAL EXCELLENCE CITATION**

The Clinical Excellence Citation is an honor bestowed upon a graduating student for outstanding performance in doctor-patient relationships. Upon recommendation by the HC Administration Group, the intern is chosen on the basis of the following criteria and conditions:

- Completion of all clinical requirements including 350 or more patient visits on or before the last day of the second month of the graduation quarter.
- Review of the candidates Health Center Mentor file, including any Notice of Praise or Notice of Concern statements and all Health Center examination results.
- Clinical knowledge and judgment
- Chiropractic adjusting skills
- Communication and interpersonal skills
- Professional attitude and behavior
- Quality of record-keeping
- Leadership
- Overall commitment to excellence
- Following review of the HC Mentor file, the remaining candidates must be approved by each of the Health Center department administrators (Competency, Quality Assurance, and Imaging).
- Final determination will be made by a vote of the Health Center faculty and administrators.

The recipient of the Clinical Excellence Citation will receive his or her award during the college's graduation ceremony.
STANDARD PROCESS PROCEDURES

Interns that have passed both the Basic and Applied Nutrition classes and have completed the Standard Process training are able to recommend Standard Process products in their patient care plans. These interns are identified by their SP pins as well as their technique badge designation.

The 4 approved supplements for distribution by LCCW Interns include:

- General Health Supplement pack
- Bone Health Supplement pack
- Adrenal Health Supplement pack
- General Female Endocrine

Procedures and Guidelines:

1. The intern will utilize the Narrative template and document supporting evidence from the ROS & Wellness questionnaire in order to justify recommendations for supplementation in their care plans.

2. Recommended schedule is to match the recommendations on the Standard Process box, package or bottle verbatim. No other recommendations will be approved by any Health Center Faculty.

3. The care plan is approved and signed off at the CMR appointment.

4. Supplement recommendations need to match with the re-eval schedule. In order for the patient to purchase additional supplements, the re-eval date must be current.

5. Prior to the first purchase, the Informed Consent form which includes consent for nutritional and herbal supplementation must be delivered by a Health Center Faculty and signed by the patient.

6. The intern will document in the SOAP note any date of supplement purchase.

7. The Health Center Faculty will circle the 100 Misc section of the visit slip and write in the specific product approved for purchase (This verified on the CMR Actions page).

8. The Health Center Faculty will document approval in the Faculty Notes page.


10. The front desk Chiropractic Assistant will collect payment and dispense product based on the HC Faculty Initials & indication of the specific product on the visit slip.

11. In the case that we do not have the product in stock, payment may be collected and the product given to the patient on their next scheduled visit or be available for pick up.

FOOTLEVELERS

A Footlevelers Scan is performed at the Intake exam. The scan is performed at no cost to the patient. Students receive 2 pairs of complementary Footlevelers. They receive their first set of Footlevelers as freshman patients. They receive an additional pair in their Student Clinic 1 quarter as part of their reciprocal patient exam. Outpatient, Outpatient Courtesy and Student Courtesy cost for a pair of Footlevelers is $125. The scanning process and procedure is taught in the classroom so that by Student Clinic 1 interns are prepared to scan their reciprocal patient.
The Administration of the College/Health Center reserves the right to add, delete, or modify the Health Center’s policies and procedures as needed.
# CMR ASSESSMENT

## CMR REVIEW FORM

**Mentor/Faculty User Name:** mmasa • **Intern User Name:** ZZ_Other  
**Patient File Number:** 0000000A • **Assessment Date:** February 23, 2017

### Type of Exam
- [ ] Initial  
- [ ] Transfer  
- [ ] Reactivation  
- [ ] Re-evaluation

### Patient’s Reason for Seeking Care

<table>
<thead>
<tr>
<th>Inadequate</th>
<th>Needs Improvement</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarification needed in 3 or more areas of history; Intern must return to patient to provide information; Intern misses critical components of history; Inadequate info</td>
<td>Clarification is needed in 2 areas of history; Information is not known and intern must return to patient to provide information</td>
<td>History is complete and accurate; Addresses all complaints; Info is clear and concise</td>
<td></td>
</tr>
</tbody>
</table>

### ROS/Wellness Questionnaire

<table>
<thead>
<tr>
<th>Inadequate</th>
<th>Needs Improvement</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarification/Information is need in 3 or more areas; Intern must return to patient to provide information; Intern misses Red flag finding in ROS (i.e., cancer, MVA, etc.); Inadequate info</td>
<td>Clarification/additional information is needed in 2 areas of ROS/Wellness questionnaire; Information is not known and intern must return to patient to provide information</td>
<td>ROS and Wellness questionnaires are fully explained; No clarification is needed</td>
<td></td>
</tr>
</tbody>
</table>

### Clinical Impression/DDX

<table>
<thead>
<tr>
<th>Inadequate</th>
<th>Needs Improvement</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only compliant with modifier and subsitution(s) are listed OR DDx are not listed; Does not have adequate information</td>
<td>Two parts of the clinical impression (A-D) are missing; DDx are not listed and appropriate for complaint</td>
<td>Includes A) compliant with modifiers, B) specific area of subsitution, C) condition most likely causing complaint and (D) co-morbidities; Appropriate DDx(s) for each complaint</td>
<td></td>
</tr>
</tbody>
</table>

### Appropriate exams selected

<table>
<thead>
<tr>
<th>Inadequate</th>
<th>Needs Improvement</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>No exams were selected OR More than two appropriate exam was not selected; No faculty signature obtained at the end of the history; Red Flag exams are missed, request for outside records not marked when indicated</td>
<td>Two appropriate exams was not selected; Faculty signature obtained at the end of the history</td>
<td>One appropriate exam was not selected; Faculty Signature obtained at the end of the history</td>
<td>All appropriate exams selected by the intern based upon patient history and ROS; Request for outside records appropriately marked; History signed by faculty; Red Flag exams were performed</td>
</tr>
</tbody>
</table>
TABLE OF CONTENTS

Inadequate
More than 3 areas (A-E) were not completed
Needs Improvement
Three areas (A-F) were not completed
Meets Expectations
One to two areas (A-F) were not completed
Exceeds Expectations
All areas (A-F) were completed: (B) All areas of exam were filled out (C) Positive findings fully explained (D) Undocumented imaging appear appropriate for exam (E) Substitution listings were written. (F) Imaging (Echocardiogram, Radiograph) included
Summary page was correctly filled out including all patient info, complete, pertinent applicable findings, and if (E) (Exams signed by faculty)

NARRATIVE

Inadequate
The diagnosis was not complete and was not diagnostic
Needs Improvement
Two areas (A-C) were not complete and not diagnostic
Meets Expectations
One of the areas (A-C) was complete and diagnostic
Exceeds Expectations
Three areas (A-C) were complete and diagnostic
Summary page was correctly filled out indicating all patient info, complete, pertinent applicable findings, and if

Diagnosis/D/DX

Inadequate
The diagnosis was not complete and was not diagnostic
Needs Improvement
Two areas (A-C) were not complete and not diagnostic
Meets Expectations
One of the areas (A-C) was complete and diagnostic
Exceeds Expectations
Three areas (A-C) were complete and diagnostic
Summary page was correctly filled out indicating all patient info, complete, pertinent applicable findings, and if

Prognosis/Goals of care

Inadequate
Prognosis was not consistent with presenting patient information, AND only included 1 of (A-C)
Meets Expectations
Prognosis was consistent with presenting patient information, AND
Exceeds Expectations
Prognosis was consistent with presenting patient information, AND

CMR continue
**TABLE OF CONTENTS**

**CASE MANAGEMENT**

<table>
<thead>
<tr>
<th><strong>Inadequate</strong></th>
<th><strong>Needs Improvement</strong></th>
<th><strong>Meets Expectations</strong></th>
<th><strong>Exceeds Expectations</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Technique, PT modality or MT modality</td>
<td>Technique, PT modality or MT modality</td>
<td>Technique, PT modality or MT modality</td>
<td>Technique, PT modality or MT modality</td>
</tr>
<tr>
<td>Diagnosis not appropriately indicated</td>
<td>Rehabilitative exercises were appropriate and included only 1 of (A-D)</td>
<td>Frequency and/or re-evaluation time not addressed</td>
<td>Exercise were appropriate and included only 3 of (A-D)</td>
</tr>
<tr>
<td>Frequency and/or re-evaluation time was not addressed</td>
<td>Frequency and/or re-evaluation time was not addressed</td>
<td>Frequency and/or re-evaluation time was not addressed</td>
<td>Frequency and/or re-evaluation time was not addressed</td>
</tr>
</tbody>
</table>

### Area:

<table>
<thead>
<tr>
<th>Area</th>
<th>Please select Yes, No, or NA</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proper Order</td>
<td>☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>Legible/Comprehensible</td>
<td>☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>Pertinent Data filled in</td>
<td>☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>Medical records request form completed</td>
<td>☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>CMR completed w/in 5 working days</td>
<td>☐ ☐ ☐</td>
<td></td>
</tr>
</tbody>
</table>

You have not completed assessment form for this intern...

Please click NEXT to submit!

**Intern Name**: ZZ-Other

**Clinic Level**: SCI

Which area this intern would need remediation? (Optional)

**GENERAL COMMENTS ON CMR:**

---

*Last page - Return to CMR in Section 1*
# REPORT OF FINDINGS ASSESSMENT FORM

**Mentor/Faculty User Name:** nmessa  -  Intern User Name: ZZ_Other  
**Patient File Number:** 0000000A  -  **Assessment Date:** February 23, 2017

## COMMUNICATION SKILLS

**Intern explained overall findings**

<table>
<thead>
<tr>
<th>Inadequate</th>
<th>Novice</th>
<th>Competent</th>
<th>Proficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intern's terminology was inappropriate—too complex/too simplified. Overall findings were not explained.</td>
<td>Intern used very little lay terms and not all findings were explained.</td>
<td>Intern used mostly lay terms; some explanations regarding overall findings were given.</td>
<td>Intern used lay terms to explain findings; appropriate explanations were given to patient regarding overall findings.</td>
</tr>
</tbody>
</table>

**Did patient present with a complaint?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Was any x-ray taken on patient?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

## Intern explained x-ray findings

<table>
<thead>
<tr>
<th>Inadequate</th>
<th>Novice</th>
<th>Competent</th>
<th>Proficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intern did not discuss x-ray findings with patient.</td>
<td>Intern briefly explained x-ray findings with patient.</td>
<td>Intern thoroughly explained and correlated x-ray findings with patient presentation. May not have discussed imaging and correlated findings sufficiently during appropriate time at HOF.</td>
<td>Intern thoroughly explained and correlated x-ray findings with patient presentation.</td>
</tr>
</tbody>
</table>

## Intern explained length of care plan

<table>
<thead>
<tr>
<th>Inadequate</th>
<th>Novice</th>
<th>Competent</th>
<th>Proficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency and duration of visits not discussed with patient.</td>
<td>Frequency and duration of visits discussed with patient.</td>
<td>Frequency and duration of visits discussed with patient. Explanation of need and importance of visits discussed.</td>
<td>Frequency of visits, duration, and medical/technical implications of consultation discussed with patient. Importance of visits discussed.</td>
</tr>
</tbody>
</table>

**ROF continues**
**TABLE OF CONTENTS**

<table>
<thead>
<tr>
<th>Inadequate</th>
<th>Novice</th>
<th>Competent</th>
<th>Proficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intern did not include any goals of care (FF/CP)</td>
<td>Intern may have included one or more goals of care (FF/CP)</td>
<td>Intern clearly explained goals of care</td>
<td>Intern clearly explained goals of care and other factors influencing care (FF/CP)</td>
</tr>
</tbody>
</table>

**Intern explained the goals of care with the patient:** Health Risks/Wellness issues, public status, behavior and lifestyle.

*Consideration of cultural sensitivity (patient’s affinity & cultural beliefs) and socio-economic status.*

<table>
<thead>
<tr>
<th>Inadequate</th>
<th>Novice</th>
<th>Competent</th>
<th>Proficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intern did not give handouts to patient and did not explain these</td>
<td>Intern may have included one or more handouts</td>
<td>Intern clearly explained handouts and discussion of handouts</td>
<td>Intern clearly explained handouts and other information provided to patient</td>
</tr>
</tbody>
</table>

**Use of visual aids**

<table>
<thead>
<tr>
<th>Inadequate</th>
<th>Novice</th>
<th>Competent</th>
<th>Proficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>No visual aids were present during ROF</td>
<td>Visual aids were present but not used in ROF</td>
<td>Visual aids were present, may not have been used appropriately or in relation to patient findings</td>
<td>Visual aids were present and used appropriately to educate patient</td>
</tr>
</tbody>
</table>

**Included chiropractic philosophy**

<table>
<thead>
<tr>
<th>Inadequate</th>
<th>Novice</th>
<th>Competent</th>
<th>Proficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intern did not include chiropractic philosophy or talk about subluxations in ROF</td>
<td>Intern briefly explained subluxation and other chiropractic philosophy</td>
<td>Intern clearly explained subluxation and only briefly mentioned any other expansion of chiropractic philosophy</td>
<td>Intern clearly explained chiropractic philosophy, included subluxation, causes of them &amp; negative effects they have</td>
</tr>
</tbody>
</table>
### Table of Contents

**Health Center Manual: Section 4**

Last page - Return to ROF Assessment in Section 1
TABLE OF CONTENTS

PATIENT VISIT ENCOUNTER ASSESSMENT

Documentation

---

PATIENT ENCOUNTER EVALUATION FORM

Do the patient’s SOAP notes legible?

No

Are the patient’s SOAP notes in back/blank pages and completed with the same inpatient?

Yes

Is there documentation in the SOAP notes referring to patient compliance?

No

---

DOCUMENTATION SOAP

1. Inadequate Order Transcription: Occurred current errors (Handwritten)

2. Novice

3. Competent

4. Proficient

Documenting seven or more ICD-9 codes

Subjective: Response to the health

Objective: Test findings

Assessment: 

Plan: 

---

PVE continues
### TABLE OF CONTENTS

#### SUBJECTIVE

Your answer was: **Inadequate**  
(Major transgressions occurred or minor errors habitually exhibited)

Please provide comments:

<table>
<thead>
<tr>
<th>VAS used for stiffness, tension, tightness</th>
<th>Patient's complaints are not updated</th>
<th>Statements are not clear, neat, or incomplete</th>
<th>No response to care</th>
</tr>
</thead>
<tbody>
<tr>
<td>No clinically useful statements documented</td>
<td>Incomplete patient information</td>
<td>No response to test visit</td>
<td>Other:</td>
</tr>
</tbody>
</table>

#### OBJECTIVE

Your answer was: **Inadequate**  
(Major transgressions occurred or minor errors habitually exhibited)

Please provide comments:

<table>
<thead>
<tr>
<th>Section is blank</th>
<th>Findings for only the segment being adjusted are documented</th>
<th>No specific plane of restriction is documented</th>
<th>Full spine findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is not a minimum of 3 findings</td>
<td>Segmental ROMs are listed as decreased</td>
<td>Information is unclear</td>
<td>Other:</td>
</tr>
</tbody>
</table>

#### ASSESSMENT

Your answer was: **Inadequate**  
(Major transgressions occurred or minor errors habitually exhibited)

Please provide comments:

<table>
<thead>
<tr>
<th>Modifiers are listed for the subluxation</th>
<th>Only the notation of &quot;VAS&quot; is made, without region/level of the subluxation</th>
<th>Doesn't match G/O</th>
<th>Complaint</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section is blank</td>
<td>Complaint with modifiers is not documented</td>
<td>No modifier</td>
<td>Other:</td>
</tr>
</tbody>
</table>

#### PLAN

Your answer was: **Inadequate**  
(Major transgressions occurred or minor errors habitually exhibited)

Please provide comments:

<table>
<thead>
<tr>
<th>Section is blank</th>
<th>Missing two or more testing, technique, patient position, and/or doctor set up</th>
<th>Free of care increase</th>
<th>PT location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intern has only listed segments to be adjusted</td>
<td>Area of PT application and home care are not listed</td>
<td>Home instructions</td>
<td>Other:</td>
</tr>
</tbody>
</table>
TABLE OF CONTENTS

PATIENT ENCOUNTER EVALUATION FORM

Patient: John Doe
Patient File Number: 123456
Assessment Date: February 12, 2017

DOCUMENTATION: How was proof of subluxation-P.A.R.T provided?

<table>
<thead>
<tr>
<th>Inadequate</th>
<th>Noise</th>
<th>Competent</th>
<th>Proficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate documentation of 1 component with the combination of P and T</td>
<td>Evidence by 2 components of the subluxation</td>
<td>Subluxation verified and samples proof of the presence of subluxation with a combination of 3 or 4 components of the P.A.R.T system</td>
<td>Subluxation verified and samples proof of the presence of a subluxation with a combination of 1 or 2 components of the P.A.R.T system</td>
</tr>
</tbody>
</table>

Which components were documented?

- P: Pain/Tenderness
- A: Anterior/Posterior
- R: Rotation
- T: Translation

DOCUMENTATION: CHECK LIST AND COMMENT

Please check if any of the following apply:

- No post or pre-treatment (Put "No ORCID" on pink for today’s visit)
- CMR Management plan not signed by patient
- Referral listed above
- Blue dot

COMMENT ON DOCUMENTATION (Optional):

PVE continues
Adjustment Skills

Adjustment Skills for Each Region
Check one region for adjustment.

C T L P E

Adjustment Skill for Region: Cervical
Please check all techniques utilized to address subluxation in this region:

Core Techniques:
- DIV
- DROP
- GON
- TOGGLE
- EXTREM
- N/A

Non-Core Techniques:
- Epic (Advoc)
- Nuxca
- AMCT
- Blair
- CBP Ml
- SU
- Knee Chest
- SOT
- N/A

Adjustment Skill for Cervical:

<table>
<thead>
<tr>
<th>1. Inadequate (Major errors or omissions)</th>
<th>2. Novice (No major errors; Multiple minor errors were corrected)</th>
<th>3. Competent (No major errors; Minor errors were corrected)</th>
<th>4. Proficient (No errors of any kind)</th>
<th>NA (Please explain)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT SET-UP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Placement</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Instructions/Assistance</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Proper Correction/Equipment</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Correct Technique Protocol</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>DOCTOR SET-UP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stance and Side</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Segmental Contact Point</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Contact Hand</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Stabilization</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>APPLICATION OF THRUST</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOC/LID Thrust/Torque</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Effective body posture/position</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Pre-tension/joint isolation</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
### Patient Placement

*Your answer was: 2. Novice*

*(No major errors; Multiple minor errors were corrected)*

Please provide comments:

<table>
<thead>
<tr>
<th>No face paper</th>
<th>Fair to poor precision/accuracy</th>
<th>Multiple attempts</th>
<th>Too much rotation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrong set-up</td>
<td>Basic, good for intern's level</td>
<td>Need more Ext/Lat Flexion</td>
<td>Other:</td>
</tr>
</tbody>
</table>

### Instructions/Assistance

*Your answer was: 2. Novice*

*(No major errors; Multiple minor errors were corrected)*

Please provide comments:

<table>
<thead>
<tr>
<th>None to fair delivery</th>
<th>None to fair precision</th>
<th>Didn't assist patient, if needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>None to fair clarity</td>
<td>Basic, good for intern's level</td>
<td>Other:</td>
</tr>
</tbody>
</table>

### Proper Correction/Equipment

*Your answer was: 2. Novice*

*(No major errors; Multiple minor errors were corrected)*

Please provide comments:

<table>
<thead>
<tr>
<th>Unfamiliar with equipment</th>
<th>Basic, good for intern's level</th>
<th>Too much rotation</th>
<th>Need guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>No precision or accuracy</td>
<td>Multiple attempts</td>
<td>Too forceful or Insufficient force</td>
<td>Other:</td>
</tr>
</tbody>
</table>

### Correct Technique Protocol

*Your answer was: 2. Novice*

*(No major errors; Multiple minor errors were corrected)*

Please provide comments:

<table>
<thead>
<tr>
<th>Unfamiliar with protocol</th>
<th>Multiple attempts</th>
<th>No major errors, multiple minor errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic, good for intern's level</td>
<td>Need guidance</td>
<td>Other:</td>
</tr>
</tbody>
</table>

### Stance and Side

*Your answer was: 2. Novice*

*(No major errors; Multiple minor errors were corrected)*

Please provide comments:

<table>
<thead>
<tr>
<th>Poor stance</th>
<th>Multiple attempts</th>
<th>Not to tension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic, good for intern's level</td>
<td>Need guidance</td>
<td>Other:</td>
</tr>
<tr>
<td>Skill</td>
<td>Level</td>
<td>Error Description</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>SCCP</td>
<td>2. Novice</td>
<td>(No major errors; Multiple minor errors were corrected)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Please provide comments:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not familiar with SCCP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Multiple attempts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Basic, good for intern's level</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not to tension</td>
</tr>
<tr>
<td>Contact Hand</td>
<td>2. Novice</td>
<td>(No major errors; Multiple minor errors were corrected)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Please provide comments:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Incorrect hand and contact point</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Too forceful or Insufficient force</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Basic, good for intern's level</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not to tension</td>
</tr>
<tr>
<td>Stabilization</td>
<td>2. Novice</td>
<td>(No major errors; Multiple minor errors were corrected)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Please provide comments:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Basics, good for intern's level</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not to tension</td>
</tr>
<tr>
<td>LOC/LOD Thrust/Torque</td>
<td>2. Novice</td>
<td>(No major errors; Multiple minor errors were corrected)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Please provide comments:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not to tension</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Basic, good for intern's level</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Depth</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inaccurate angle or direction of thrust</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Speed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Too forceful or Insufficient force</td>
</tr>
<tr>
<td>Effective body posture/position</td>
<td>2. Novice</td>
<td>(No major errors; Multiple minor errors were corrected)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Please provide comments:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Poor posture</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Basic, good for intern's level</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ineffective</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adequate COG and coordination evident</td>
</tr>
</tbody>
</table>

PVE continues
### Professionalism

#### Pre-tension/joint isolation

**Your answer was: 2. Novice**

*(No major errors; Multiple minor errors were corrected)*

Please provide comments:

<table>
<thead>
<tr>
<th>Non visible</th>
<th>Too forceful or insufficient force</th>
<th>Tension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic, good for intern's level</td>
<td>Depth</td>
<td>Other</td>
</tr>
</tbody>
</table>

**General comments on adjustment skill for Cervical (Optional):**

---

### Professionalism

#### 1. Inadequate

(Major transgressions occurred or minor errors habitually exhibited)

<table>
<thead>
<tr>
<th>INTERN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teachability/Intellectual Curiosity</td>
</tr>
<tr>
<td>Demeanor/Dress Code</td>
</tr>
<tr>
<td>Respect/Attitude/Integrity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PATIENT ENCOUNTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence/Communication Skills</td>
</tr>
<tr>
<td>Time Management/Efficiency</td>
</tr>
</tbody>
</table>

#### 2. Novice

(No Major transgressions; Multiple minor errors were corrected)

<table>
<thead>
<tr>
<th>1. Inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teachability/Intellectual Curiosity</td>
</tr>
<tr>
<td>Demeanor/Dress Code</td>
</tr>
<tr>
<td>Respect/Attitude/Integrity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Novice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence/Communication Skills</td>
</tr>
<tr>
<td>Time Management/Efficiency</td>
</tr>
</tbody>
</table>

#### 3. Competent

(No major incidents; Minor incidents were resolved)

<table>
<thead>
<tr>
<th>1. Inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teachability/Intellectual Curiosity</td>
</tr>
<tr>
<td>Demeanor/Dress Code</td>
</tr>
<tr>
<td>Respect/Attitude/Integrity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Novice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence/Communication Skills</td>
</tr>
<tr>
<td>Time Management/Efficiency</td>
</tr>
</tbody>
</table>

#### 4. Proficient

(No negative incidents of any kind; specific commendable events observed)

<table>
<thead>
<tr>
<th>1. Inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teachability/Intellectual Curiosity</td>
</tr>
<tr>
<td>Demeanor/Dress Code</td>
</tr>
<tr>
<td>Respect/Attitude/Integrity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Novice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence/Communication Skills</td>
</tr>
<tr>
<td>Time Management/Efficiency</td>
</tr>
</tbody>
</table>

---

PVE continues
### TABLE OF CONTENTS

- **Teachability/Intellectual Capacity**: Your answer was 2. Novice  
  (No Major transgressions; Multiple minor errors were corrected)  
  Please provide comments:

<table>
<thead>
<tr>
<th>Does not behavior in accordance to advise and feedback offered</th>
<th>Does not express curiosity into patient condition</th>
<th>Multiple minor errors were corrected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apathetic to opportunity to improve</td>
<td>No major transgressions</td>
<td>Other:</td>
</tr>
</tbody>
</table>

- **Demeanor/Dress Code**: Your answer was 2. Novice  
  (No Major transgressions; Multiple minor errors were corrected)  
  Please provide comments:

<table>
<thead>
<tr>
<th>Performance of duties is impeded by general demeanor</th>
<th>Performance of duties is impeded by dress</th>
<th>Inappropriate clothing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance of duties is impeded by grooming</td>
<td>Performance of duties is impeded by hygiene</td>
<td>Other:</td>
</tr>
</tbody>
</table>

- **Reactivity/Attitude/Integrity**: Your answer was 2. Novice  
  (No Major transgressions; Multiple minor errors were corrected)  
  Please provide comments:

<table>
<thead>
<tr>
<th>Overtly betrays or demean other people through words or mannerisms</th>
<th>Strong attitudes or opinions are expressed to patient</th>
<th>Negativity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitude portrayed is not appropriate given their level of expertise</td>
<td>Strong attitudes or opinions are expressed to faculty</td>
<td>Other:</td>
</tr>
</tbody>
</table>

- **Confidence/Communication Skills**: Your answer was 2. Novice  
  (No Major transgressions; Multiple minor errors were corrected)  
  Please provide comments:

<table>
<thead>
<tr>
<th>Poor language skills, inappropriate terminology</th>
<th>Casual interaction with patient</th>
<th>Lack of confidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interaction is abrupt to allow intern to organize their process</td>
<td>Interacts uncomfortably</td>
<td>Other:</td>
</tr>
</tbody>
</table>

- **Time Management/Efficiency**: Your answer was 2. Novice  
  (No Major transgressions; Multiple minor errors were corrected)  
  Please provide comments:

<table>
<thead>
<tr>
<th>External or protracted patient encounter</th>
<th>Lack of organization in the interaction</th>
<th>Multiple minor errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficiency of process and assessment lead to increase in time</td>
<td>No major transgressions</td>
<td>Other:</td>
</tr>
</tbody>
</table>
Was there any issue of cultural sensitivity with this patient encounter?

Yes  No

Please click NEXT to submit!

Intern Name  ZZ  Other
Clinic Level  C1

COMMENTS ON PROFESSIONALISM (Optional):

GENERAL COMMENTS
Which area this intern would need remediation? (Optional)

Last page - Return to PVE in Section 1
# TABLE OF CONTENTS

## Qualitative Requirements

- A list of common feedback that faculty often select.
- **If a raters provides an open-ended text comment, it is recorded in the last line "Other".**

---

<table>
<thead>
<tr>
<th>Student ID</th>
<th>Total Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intern Full Name from Fall roster</td>
<td></td>
</tr>
<tr>
<td>Standard dates can be flexible, not necessary from roster</td>
<td></td>
</tr>
</tbody>
</table>

---

20 times the rater answered "yes" to the question "Are the Intern SOAP notes legible?".

**The column "#" in other sections show how many times each check box is marked or each Common Comment is selected.**

<table>
<thead>
<tr>
<th>Increment</th>
<th>SOAP Objective(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

---

20 out of 23 = 86.98%.

**The percentage show how frequent the event happens during the specified period.**

---

8 of PVE records were submitted on Qualtrics during the specified period. This number is carried over to all sections for the frequency/percentage calculations.
The intern got the score of 2 for the same criteria (11) Pre-tension/joint isolation 4 times (out of 20 PVs).

**Score displayed on Qualtrics:**
1. Inadequate
2. Novice
3. Competent
4. Proficient

Average Score is calculated based on all scores the intern got from the criteria (11) Pre-tension/joint isolation of the same adjustment.
### TABLE OF CONTENTS

[Last page - Return to QR in Section 1](#)
<table>
<thead>
<tr>
<th>Activity</th>
<th>No Difficulty</th>
<th>Mild Difficulty</th>
<th>Moderate Difficulty</th>
<th>Severe Difficulty</th>
<th>Unable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Open a tight or new jar.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Write.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Turn a key.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Prepare a meal.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Push open a heavy door.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Place an object on a shelf above your head.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Do heavy household chores (e.g., wash walls, wash floor)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Garden or do yard work.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Make a bed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Carry a shopping bag or briefcase.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Carry a heavy object (over 10 lbs).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Change a light bulb overhead.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Wash or blow dry your hair.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Wash your back.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Put on a pull-over sweater.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Use a knife to cut food.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Recreational activities which require little effort (e.g., card playing, knitting, etc.).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20. Manage transportation needs (getting from one place to another).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>21. Sexual activities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## DISABILITIES OF THE ARM, SHOULDERS AND HAND

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity Description</th>
<th>NO DIFFICULTY</th>
<th>MILD DIFFICULTY</th>
<th>MODERATE DIFFICULTY</th>
<th>SEVERE DIFFICULTY</th>
<th>UNABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Open a tight or new jar.</td>
<td>x</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2.</td>
<td>Write</td>
<td>1</td>
<td>x</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3.</td>
<td>Turn a key</td>
<td>1</td>
<td>x</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4.</td>
<td>Prepare a meal</td>
<td>1</td>
<td>x</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5.</td>
<td>Push open a heavy door</td>
<td>1</td>
<td>x</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6.</td>
<td>Place an object on a shelf above your head</td>
<td>1</td>
<td>x</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7.</td>
<td>Do heavy household chores (e.g., wash the car)</td>
<td>1</td>
<td>x</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8.</td>
<td>Garden or do yard work</td>
<td>1</td>
<td>x</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9.</td>
<td>Make a bed</td>
<td>x</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Carry a shopping bag or briefcase</td>
<td>1</td>
<td>x</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11.</td>
<td>Carry a heavy object (over 10 lbs)</td>
<td>x</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Change a light bulb overhead</td>
<td>1</td>
<td>x</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13.</td>
<td>Wash or blow dry your hair</td>
<td>1</td>
<td>x</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14.</td>
<td>Wash your back</td>
<td>1</td>
<td>x</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15.</td>
<td>Put on a pullover sweater</td>
<td>1</td>
<td>x</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16.</td>
<td>Use a knife to cut food</td>
<td>1</td>
<td>x</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17.</td>
<td>Recreational activities which require little effort (e.g., card playing, knitting, etc.)</td>
<td>1</td>
<td></td>
<td></td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>2</td>
<td>x</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20.</td>
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<td>1</td>
<td>2</td>
<td>x</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>21.</td>
<td>Sexual activities</td>
<td>1</td>
<td>2</td>
<td>x</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Rev. 12/20/16

DASH Continue
TABLE OF CONTENTS

DISABILITIES OF THE ARM, SHOULDER AND HAND

22. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups? (circle number)

<table>
<thead>
<tr>
<th>NOT AT ALL</th>
<th>SLIGHTLY</th>
<th>MODERATELY</th>
<th>QUITE A BIT</th>
<th>EXTREMELY</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? (circle number)

<table>
<thead>
<tr>
<th>NOT LIMITED AT ALL</th>
<th>SLIGHTLY LIMITED</th>
<th>MODERATELY LIMITED</th>
<th>VASTLY LIMITED</th>
<th>UNABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>X</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Please rate the severity of the following symptoms for the last week. (circle number)

<table>
<thead>
<tr>
<th>HOME</th>
<th>MILD</th>
<th>MODERATE</th>
<th>SEVERE</th>
<th>EXTREME</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>X</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

24. Arm, shoulder or hand pain.

25. Arm, shoulder or hand pain when you performed any specific activity.

26. Tingling (pins and needles) in your arm, shoulder or hand.

27. Weakness in your arm, shoulder or hand.

28. Stiffness in your arm, shoulder or hand.

29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)

<table>
<thead>
<tr>
<th>NO DIFFICULTY</th>
<th>MILD DIFFICULTY</th>
<th>MODERATE DIFFICULTY</th>
<th>SEVERE DIFFICULTY</th>
<th>SO MUCH DIFFICULTY I CAN’T SLEEP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>X</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. (circle number)

DASH DISABILITY/SYMPTOM SCORE: 14.16
A DASH score may not be calculated if there are greater than 3 missing items.

\[
\text{Score} = \left( \frac{\text{sum of } n \text{ responses}}{n} - 1 \right) \times 25, \text{ where } n \text{ is the number of completed responses.}
\]

Ex: (Score of 60/28 responses) = 2.14 - 1 = 1.14 \times 25 = 28.57

Rev. 12/20/16

Last page - Return to DASH in Section 2
### PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer)

<table>
<thead>
<tr>
<th>Item</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>□ D</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>2. Feel down, depressed or hopeless</td>
<td>□ D</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep; sleeping too much</td>
<td>□ D</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>□ D</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>□ D</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down</td>
<td>□ D</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>□ D</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>□ D</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself</td>
<td>□ D</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
</tbody>
</table>

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

For Internal Scoring Only

Add columns 1 - 9 _______ + _______ + _______.

TOTAL: __________________

(For interpretation of TOTAL, please refer to scoring instructions on the back)

---

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ACR0283 10-04-2005

Rev. 07/2017

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PHQ-9 Continue
# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things</td>
<td>✓ (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feel down, depressed or hopeless</td>
<td>(2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trouble falling or sleeping, or sleeping too much</td>
<td>(3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling tired or having little energy</td>
<td>(4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor appetite or overeating</td>
<td>(5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling bad about yourself or that you are a failure or have let yourself or your family down</td>
<td>(6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>(7)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>(8)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thoughts that you would be better off dead, or of hurting yourself</td>
<td>(9)</td>
<td></td>
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</tr>
</tbody>
</table>

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Completely difficult</th>
</tr>
</thead>
</table>

For Internal Scoring Only

Add columns 1-9 6 0 + 0 0

TOTAL: ____________

(For interpretation of TOTAL, please refer to scoring instructions on the back)

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A2R023E 10-04-2005

Rev. 07/2017
PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 √'s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder
- If there are at least 5 √'s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder
- If there are 2-4 √'s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understands the questionnaire, as well as other relevant information from the patient.

Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up √'s by column. For every √: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring box to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

Fix every √:
- Not at all = 0
- Several days = 1
- More than half the days = 2
- Nearly every day = 3

Interpretation of Total Score:

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>Minimal depression</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild depression</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate depression</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately severe depression</td>
</tr>
<tr>
<td>20-27</td>
<td>Severe depression</td>
</tr>
</tbody>
</table>

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A20028 18-04-2005
Rev. 05/2016
CUESTIONARIO SOBRE LA SALUD DEL PACIENTE - 9 (PHQ-9)

Interno: __________  Doc #: __________  Patient: __________  File #: __________  Date: __________

Durante las últimas 2 semanas, ¿qué tan seguido han surgido molestias debido a los siguientes problemas? (Marque con un "√" para indicar su respuesta)

<table>
<thead>
<tr>
<th></th>
<th>Ningún Día</th>
<th>Varios días</th>
<th>Más de la mitad de los días</th>
<th>Casi todos los días</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Poco interés o placer en hacer cosas</td>
<td>□ D</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>2. Se ha sentido decaído(a), apagado(a) o sin esperanzas</td>
<td>□ D</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>3. Ha tenido dificultad para quedar se permaneciendo dormido(a), o ha dormido demasiado</td>
<td>□</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>4. Se ha sentido cansado(a) o con poca energía</td>
<td>□ D</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>5. Sin apetito o ha comido en exceso</td>
<td>□ D</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>6. Se ha sentido maí con usted mismo(a)</td>
<td>□ D</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>---</td>
<td>□ D</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>7. Ha tenido dificultad para concentrarse en ciertas actividades, tales como leer el periódico o ver la televisión</td>
<td>□ D</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>8. ¿Se ha movido o hablado tan tanta que otras personas podrían haberlo notado? o lo contrario – muy inquieto(a) o agitado(a) que ha estado moviéndose mucho más de lo normal</td>
<td>□ D</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>9. Pensamientos de que estaría mejor muerto(a) o de lastimarse de alguna manera</td>
<td>□ D</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>10. Si marcó cualquier de los problemas, ¿qué tanto dificultad le han dado estos problemas para hacer su trabajo, encargarse de las tareas del hogar, o llevarse bien con otras personas?</td>
<td>□ D</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
</tbody>
</table>

For Internal Scoring Only

Add columns 1-9 _________ + _________ + _________

TOTAL: __________

(For interpretation of TOTAL, please refer to scoring instructions on the back)

Elaborado por los doctores Robert L. Spitzer, Janet B.W. Williams, Karl Kranke y colegas, mediante una
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Rev. 03/2017
## Generalized Anxiety Disorder 7-Item (GAD-7) Scale

<table>
<thead>
<tr>
<th>Item</th>
<th>Not at all sure</th>
<th>Several days</th>
<th>Over half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling nervous, anxious, or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Worrying too much about certain things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Being so restless that it's hard to sit</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

For internal scoring only:

Add the score for each column + + +

Total score (add your column scores) =

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Possible diagnosis of GAD; confirm by further evaluation</td>
</tr>
<tr>
<td>5</td>
<td>Mild anxiety</td>
</tr>
<tr>
<td>10</td>
<td>Moderate anxiety</td>
</tr>
<tr>
<td>15</td>
<td>Severe anxiety</td>
</tr>
</tbody>
</table>


Rev. 12/20/16
## Generalized Anxiety Disorder 7-Item (GAD-7) Scale

<table>
<thead>
<tr>
<th>Item</th>
<th>Not at all sure</th>
<th>Several days</th>
<th>Over half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious, or on edge</td>
<td>0</td>
<td>X</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop thinking and worrying</td>
<td>0</td>
<td>X</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>X</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>X</td>
</tr>
<tr>
<td>5. Being so restless that it's hard to relax</td>
<td>0</td>
<td>1</td>
<td>X</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>X</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something might happen</td>
<td>0</td>
<td>1</td>
<td>X</td>
<td>3</td>
</tr>
</tbody>
</table>

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult [X]
- Very difficult
- Extremely difficult

For Internal Scoring Only:

Add the score for each column: 6 + 3 = 12

Total Score (add your column scores): 12

### Interpreting the Score:

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥10</td>
<td>Possible diagnosis of GAD; confirm by further evaluation</td>
</tr>
<tr>
<td>5</td>
<td>Mild anxiety</td>
</tr>
<tr>
<td>10</td>
<td>Moderate anxiety</td>
</tr>
<tr>
<td>15</td>
<td>Severe anxiety</td>
</tr>
</tbody>
</table>


Rev. 12/20/16

Last page - Return to GAD-7 in Section 2
**HEADACHE DISABILITY INDEX (HDI)**

**INSTRUCTIONS:**

Please CIRCLE the correct response:

1. I have headaches:  
   (1) 1 Per month  
   (2) More than 1 but less than 4 per month  
   (3) More than one per week

2. My headaches:  
   (1) Mild  
   (2) Moderate  
   (3) Severe

*Please read carefully.* The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES," "SOMETIMES," or "NO" to each item. Answer each question as it pertains to your headache only.

<table>
<thead>
<tr>
<th>YES</th>
<th>SOMETIMES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1</td>
<td>Because of my headaches I feel handicapped.</td>
<td></td>
</tr>
<tr>
<td>E2</td>
<td>Because of my headaches I feel restricted in performing my usual daily activities.</td>
<td></td>
</tr>
<tr>
<td>E3</td>
<td>I restrict my recreational activities (eg. Sports, Hobbies) because of my headaches.</td>
<td></td>
</tr>
<tr>
<td>E4</td>
<td>My headaches make me angry.</td>
<td></td>
</tr>
<tr>
<td>E5</td>
<td>Sometimes I feel that I am going to lose control because of my headaches.</td>
<td></td>
</tr>
<tr>
<td>E6</td>
<td>Because of my headaches I am less likely to socialize.</td>
<td></td>
</tr>
<tr>
<td>E7</td>
<td>My friends, relatives, or family and friends have no idea what I am going through because of my headaches.</td>
<td></td>
</tr>
<tr>
<td>E8</td>
<td>My headaches are so bad that I feel that I am going to go insane.</td>
<td></td>
</tr>
<tr>
<td>E9</td>
<td>My outlook on the world is affected by my headaches.</td>
<td></td>
</tr>
<tr>
<td>E10</td>
<td>I am afraid to be alone when I feel that a headache is starting.</td>
<td></td>
</tr>
<tr>
<td>E11</td>
<td>I feel desperate because of my headaches.</td>
<td></td>
</tr>
<tr>
<td>E12</td>
<td>I am concerned that I am missing activities at work or at home because of my headaches.</td>
<td></td>
</tr>
<tr>
<td>E13</td>
<td>My headaches place stress on my relationships with family or friends.</td>
<td></td>
</tr>
<tr>
<td>E14</td>
<td>I avoid being around people when I have a headache.</td>
<td></td>
</tr>
<tr>
<td>E15</td>
<td>I believe my headaches are making it difficult for me to achieve my goals in life.</td>
<td></td>
</tr>
<tr>
<td>E16</td>
<td>I am unable to think clearly because of my headaches.</td>
<td></td>
</tr>
<tr>
<td>E17</td>
<td>I get tense (eg. Muscle tension) because of my headaches.</td>
<td></td>
</tr>
<tr>
<td>E18</td>
<td>I do not enjoy social gatherings because of my headaches.</td>
<td></td>
</tr>
<tr>
<td>E19</td>
<td>I feel irritable because of my headaches.</td>
<td></td>
</tr>
<tr>
<td>E20</td>
<td>I avoid traveling because of my headaches.</td>
<td></td>
</tr>
<tr>
<td>E21</td>
<td>My headaches make me feel confused.</td>
<td></td>
</tr>
<tr>
<td>E22</td>
<td>My headaches make me feel frustrated.</td>
<td></td>
</tr>
<tr>
<td>E23</td>
<td>I find it difficult to read because of my headaches.</td>
<td></td>
</tr>
<tr>
<td>E24</td>
<td>I find it difficult to focus my attention away from my headaches and on other things.</td>
<td></td>
</tr>
</tbody>
</table>

*Rev. 3/2017*
## HEADACHE DISABILITY INDEX (HDI)

**Instructions:**
Please CIRCLE the correct response:
1. I have headaches: (1) 1 Per month  (2) More than 1 but less than 4 per month  (3) More than one per week
2. My headaches: (1) Mild  (2) Moderate  (3) Severe

Please Read Carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off “YES”, “SOMETIMES”, or “NO” to each item. Answer each question as it pertains to your headache only.

<table>
<thead>
<tr>
<th>YES</th>
<th>SOMETIMES</th>
<th>NO</th>
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<tbody>
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</tbody>
</table>
TABLE OF CONTENTS

INSTRUCTIONS:
Using this system, if “YES” is checked on any given line, that answer is given 4 points, “SOMETIMES” answer is given 2 points and a “NO” answer is given zero.

\[ \text{HDI} = \frac{48}{100} = 0.48 \times 100 = 48\% \]

Interpreting the Score:

<table>
<thead>
<tr>
<th>HDI Score Range</th>
<th>Disability Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-28%</td>
<td>Mild disability</td>
</tr>
<tr>
<td>30-49%</td>
<td>Moderate disability</td>
</tr>
<tr>
<td>50-68%</td>
<td>Severe disability</td>
</tr>
<tr>
<td>72%</td>
<td>Extreme disability</td>
</tr>
</tbody>
</table>


Rev. 3/2017

Last page - Return to HDI in Section 2
TABLE OF CONTENTS

THE ROLAND-MORRIS LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (RM-LB)

Initial: ___________ Doc #: _________ Patient: ___________ File #: _________ Date: ___________

Please read instructions: When your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

1. ☐ I stay at home most of the time because of my back.
2. ☐ I change position frequently to try to get my back comfortable. I walk more slowly than usual because of my back.
3. ☐ Because of my back, I am avoiding activities that I usually do around the house. Because of my back, I use a handrail to get upstairs.
4. ☐ Because of my back, I lie down a lot more often.
5. ☐ Because of my back, I have to have someone help me to get out of an easy chair. Because of my back, I try to get other people to do things for me.
6. ☐ I get dressed more slowly than usual because of my back.
7. ☐ I only stand up for short periods of time because of my back. Because of my back, I try not to bend or kneel down.
8. ☐ I find it difficult to get out of a chair because of my back. My back is painful almost all of the time.
9. ☐ I find it difficult to turn over in bed because of my back. My back is painful almost all of the time.
10. ☐ I have trouble putting on my socks (or stockings) because of the pain in my back. I can only walk short distances because of my back pain.
11. ☐ I sleep less well because of my back.
12. ☐ Because of my back pain, I get dressed with the help of someone else. I sit down for most of the day because of my back.
13. ☐ I avoid heavy jobs around the house because of my back.
14. ☐ Because of back pain, I am more irritable and bad tempered than usual. Because of my back, I go upstairs more slowly than usual.
15. ☐ I stay in bed most of the time because of my back.

For Internal Scoring Only

Instructions:
1. The patient is instructed to put a mark next to each appropriate statement.
2. The total number of marked statements are added by the clinician. Unlike the authors of the Oswestry Disability Questionnaire, Roland and Morris did not provide descriptions of the varying degrees of disability (e.g., 40%-60% is severe disability).
3. Clinical improvement over time can be graded based on the analysis of serial questionnaire scores. If, for example, at the beginning of treatment, a patient's score was 12 and, at the conclusion of treatment, her score was 2 (10 points of improvement), we would calculate an 83% (10/12 x 100) improvement.

TOTAL: (___/15) x 100 = ____%  

RM-LB Continue
THE ROLAND-MORRIS LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (RM-LB)

Inter: SAMPLE  Dec #:  Patient:  File #:  Date:  

Please read instructions: When your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

1. □ I stay at home most of the time because of my back.
2. X I change position frequently to try to keep my back comfortable. I walk more slowly than usual because of my back.
3. X Because of my back, I am not doing my job that I usually do around the house. Because of my back, I use a handrail to get upstairs.
4. □ Because of my back, I lie down to rest most of the time.
5. □ Because of my back, I have to ask someone to get out of an easy chair. Because of my back, I try to get other people to do things for me.
6. □ I get dressed more slowly than usual because of my back.
7. □ I only stand up for short periods of time because of my back. Because of my back, I try not to bend or kneel down.
8. □ I find it difficult to get out of a chair because my back or my back is painful most of the time.
9. □ I find it difficult to turn over in bed because of my back. My appetite is not very good because of my back.
10. □ I have trouble putting on my socks (or stockings) because of the pain in my back. I can only walk short distances because of my back pain.
11. □ I sleep less well because of my back.
12. □ Because of my back pain, I get dressed with the help of someone else. I sit down for most of the day because of my back.
13. □ I avoid heavy jobs around the house because of my back.
14. X Because of back pain, I am more irritable and bad tempered than usual. Because of my back, I go upstairs more slowly than usual.
15. □ I stay in bed most of the time because of my back.

For Internal Scoring Only:

Instructions:
1. The patient is instructed to put a mark next to each appropriate statement.
2. The total number of marked statements are added by the clinician. Unlike the authors of the Oswestry Disability Questionnaire, Roland and Morris did not provide descriptions of the varying degrees of disability (e.g., 40%-60% is severe disability).
3. Clinical improvement over time can be graded based on the analysis of serial questionnaire scores. If, for example, at the beginning of treatment, a patient’s score was 12 and, at the conclusion of treatment, her score was 2 (10 points of improvement), we would calculate an 83% (19/12 x 100) improvement.

TOTAL: ( _7__/ 15) x 100 = 46.66 %

Rev. 3/5/2017

Last page - Return to RM-LB in Section 2
# THE LOWER EXTREMITY FUNCTIONAL SCALE (LEFS)

<table>
<thead>
<tr>
<th>Activities</th>
<th>Extreme Difficulty</th>
<th>Quite a Bit of Difficulty</th>
<th>Moderate Difficulty</th>
<th>A Little Bit of Difficulty</th>
<th>No Difficulty</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Get up from a seated position</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2. Get in and out of a car, or a chair</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>3. Getting into and out of the bath</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>4. Walking between rooms</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>5. Pulling on your clothes or socks</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>6. Squatting</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>7. Lifting an object, like a bag of groceries, one at a time</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>8. Performing light activities around your home</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>9. Bathing your extremities around your home</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>10. Bathing in water around your home</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>11. Walking 2 blocks</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>12. Walking a mile</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>13. Going up and down 1 flight (please right and left)</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>14. Standing for 1 hour</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>15. Sitting for 1 hour</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>16. Dressing or undressing</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
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<tr>
<td>17. Running up stairs</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
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<tr>
<td>18. Making sharp turns while running fast</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>19. Stepping</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
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<tr>
<td>20. Rolling over in bed</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Column Totals:</th>
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<tbody>
<tr>
<td>Minimum Level of Detectable Change (5% Confidence): 1 point SCORER</td>
</tr>
</tbody>
</table>

For Internal Scoring Only

Minimum Level of Detectable Change (5% Confidence): 1 point. SCORER (Fill in the blank with the sum of your scores)
# TABLE OF CONTENTS

**SAMPLE**

Last page - Return to LEFS in Section 2
THE MIGRAINE DISABILITY ASSESSMENT TEST (MIDAS)

Int: __________ D: __________ P: __________ F: __________ D: __________

The MIDAS (Migraine Disability Assessment) questionnaire was put together to help you measure the impact your headaches have on your life. The information on this questionnaire is also helpful for your primary care provider to determine the level of pain and disability caused by your headaches and to find the best treatment for you.

INSTRUCTIONS
Please answer the following questions about ALL of the headaches you have had over the last 3 months. Select your answer in the box next to each question. Select zero if you did not have the activity in the last 3 months.

1. On how many days in the last 3 months did you miss work or school because of your headache?

2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)

3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?

4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches (Do not include days you counted in question 3 where you did not do household work.)

5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?

For Internal Scoring Only:

Total MIDAS Score: __________

Headache Frequency (how many headaches in the last 3 months): __________

Headache Severity (on 0-10 pain scale): __________

Scoring: Add the total number of days from questions 1-5 only. TOTAL: __________

<table>
<thead>
<tr>
<th>MIDAS Grade</th>
<th>Definition</th>
<th>MIDAS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Little or no disability</td>
<td>0-5</td>
</tr>
<tr>
<td>II</td>
<td>Mild disability</td>
<td>6-10</td>
</tr>
<tr>
<td>III</td>
<td>Moderate disability</td>
<td>11-20</td>
</tr>
<tr>
<td>IV</td>
<td>Severe disability</td>
<td>21+</td>
</tr>
</tbody>
</table>

This survey was developed by Richard B. Lipton, MD, Professor of Neurology, Albert Einstein College of Medicine, New York, NY, and Walter F. Sloan, MPH, PhD, Associate Professor of Epidemiology, Johns Hopkins University, Baltimore, MD.

THE MIGRAINE DISABILITY ASSESSMENT TEST (MIDAS)

Internal: _______  Date: __________  Patient: _____________________  File #: _______

The MIDAS (Migraine Disability Assessment) questionnaire was put together to help you measure the impact your headaches have on your life. The information on this questionnaire is also helpful for your primary care provider to determine the level of pain and disability caused by your headaches and to find the best treatment for you.

INSTRUCTIONS
Please answer the following questions about ALL of the headaches you have had over the last 3 months. Select your answer in the box next to each question. Select zero if you did not have the activity in the last 3 months.

7
   1. On how many days in the last 3 months did you miss work or school because of your headache?

   ___

14
   2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)

   ___

18
   3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?

   ___

15
   4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)

   ___

5
   5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?

   ___

For Internal Scoring Only:

Total MIDAS Score: ___ 54 ___

Headache Frequency (how many headaches in the last 3 months) ___

Headache Severity (on 0-10 pain scale) ___

Scoring: Add the total number of days from questions 1-5 only. TOTAL: ___ 54 ___

<table>
<thead>
<tr>
<th>MIDAS Grade</th>
<th>Definition</th>
<th>MIDAS Score</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>II</td>
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<td>11-20</td>
</tr>
<tr>
<td>IV</td>
<td>Severe disability</td>
<td>21+</td>
</tr>
</tbody>
</table>

This survey was developed by Richard B. Lipton, M.D., Professor of Neurology, Albert Einstein College of Medicine, New York, New York, and Walter F. Bloss, MPH, PhD, Associate Professor of Epidemiology, Johns Hopkins University, Baltimore, MD

Last page - Return to MIDAS in Section 2
This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you. We realize you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1: PAIN INTENSITY
- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is severe at the moment
- The pain is the worst imaginable at the moment

SECTION 2: PERSONAL CARE (WASHING, DRESSING, ETC.)
- I can look after myself normally without any pain
- I can look after myself normally but it causes some pain
- It is painful for me to look after myself and I am slow in doing it
- I need some help but can manage most of my personal care
- I need help every day in most aspects of self care
- I do not get dressed, wash with difficulty and stay in bed

SECTION 3: LIFTING
- I can lift heavy weights without extra pain
- I can lift heavy weights but it causes extra pain
- Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example in a table
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything

SECTION 4: READING
- I can read as much as I want to with no pain in my neck
- I can read as much as I want to with slight pain in my neck
- I can read as much as I want with moderate pain in my neck
- I can’t read as much as I want because of moderate pain in my neck
- I can hardly read at all because of severe pain in my neck
- I cannot read at all

SECTION 5: HEADACHES
- I have no headaches at all
- I have slight headaches which come infrequently
- I have moderate headaches, which come infrequently
- I have moderate headaches, which come frequently
- I have severe headaches, which come frequently
- I have headaches almost all the time

SECTION 6: CONCENTRATION
- I can concentrate fully when I want to with no difficulty
- I can concentrate fully when I want to with slight difficulty
- I have a fair degree of difficulty in concentrating when I want to
- I have a lot of difficulty in concentrating when I want to
- I have a great deal of difficulty in concentrating when I want to
- I cannot concentrate at all

SECTION 7: WORK
- I can do as much work as I want to
- I can only do my usual work, but no more
- I can do most of my usual work, but no more
- I cannot do my usual work
- I can hardly do any work at all
- I cannot do any work at all

SECTION 8: DRIVING
- I can drive my car without any neck pain
- I can drive my car as long as I want with slight pain in my neck
- I can drive my car as long as I want with moderate pain in my neck
- I can drive my car as long as I want because of moderate pain in my neck
- I cannot drive my car as long as I want because of severe pain in my neck
- I cannot drive my car at all

SECTION 9: SLEEP
- I have no sleep problems
- My sleep is moderately disturbed (1-2 hrs sleepless)
- My sleep is not usually disturbed (2-3 hrs sleepless)
- My sleep is typically disturbed (3-5 hrs sleepless)
- My sleep is completely disturbed (3-7 hrs sleepless)

SECTION 10: RECREATION
- I am able to engage in all my recreation activities with no neck pain at all
- I am able to engage in all my recreation activities, with some pain in my neck
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
- I am able to engage in few of my usual recreation activities because of pain in my neck
- I can hardly do any recreation activities because of pain in my neck
- I cannot do any recreation activities at all
TABLE OF CONTENTS

NECK DISABILITY INDEX (NDI) – VERNON MIOR

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you. We realize you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

<table>
<thead>
<tr>
<th>SECTION 1: PAIN INTENSITY</th>
<th>SECTION 6: CONCENTRATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>X I have no pain at the moment</td>
<td>X I have a fair degree of difficulty in concentrating when I want to</td>
</tr>
<tr>
<td>□ The pain is very mild at the moment</td>
<td>□ I have a lot of difficulty in concentrating when I want to</td>
</tr>
<tr>
<td>□ The pain is moderate at the moment</td>
<td>□ I have a great deal of difficulty in concentrating when I want to</td>
</tr>
<tr>
<td>□ The pain is fairly severe at the moment</td>
<td>□ I cannot concentrate at all</td>
</tr>
<tr>
<td>□ The pain is very severe at the moment</td>
<td></td>
</tr>
<tr>
<td>□ The pain is the worst imaginable at the moment</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION 2: PERSONAL CARE (WASHING ETC.)</th>
</tr>
</thead>
</table>

X I can look after myself normally without causing pain
□ I can look after myself normally but it causes some pain
□ It is painful to look after myself and I am slow and careful
□ I need some help but can manage most of my personal care
□ I need help every day in most aspects of self care
□ I do not get dressed, wash with difficulty and stay in bed

<table>
<thead>
<tr>
<th>SECTION 3: LIFTING</th>
</tr>
</thead>
</table>

X I can lift heavy weights without extra pain
□ I can lift heavy weights but it gives extra pain
□ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table
□ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
□ I can only lift very light weights
□ I cannot lift or carry anything

<table>
<thead>
<tr>
<th>SECTION 4: READING</th>
</tr>
</thead>
</table>

X I can read as much as I want to with no pain in my neck
□ I can read as much as I want to with slight pain in my neck
□ I can read as much as I want to with moderate pain in my neck
□ I can read as much as I want because of moderate pain in my neck
□ I can hardly read at all because of severe pain in my neck
□ I cannot read at all

<table>
<thead>
<tr>
<th>SECTION 5: HEADACHES</th>
</tr>
</thead>
</table>

□ I have no headaches at all
□ I have slight headaches, which come infrequently
X □ I have moderate headaches, which come infrequently
□ I have moderate headaches, which come frequently
□ I have severe headaches, which come frequently
□ I have headaches almost all the time

<table>
<thead>
<tr>
<th>SECTION 10: RECREATION</th>
</tr>
</thead>
</table>

X □ I am able to engage in all my recreation activities with no neck pain at all
□ I am able to engage in all my recreation activities, with some pain in my neck
□ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
□ I am able to engage in a few of my usual recreation activities because of pain in my neck
□ I can hardly any recreation activities because of pain in my neck
□ I can’t do any recreation activities at all

Rev. 3/2017
For Internal Scoring Only

Score: ___12___ / 50 Transform to percentage score x 100 = ___24___

Scoring Instructions:
For each section the total possible score is 5: if the first statement is marked the section score = 0; if the last statement is marked, it = 5. If all 10 sections are completed the score is calculated as follows:

Example: 16 (total scored) 
50 (total possible score) x 100 = 32%

If one section is missed or not applicable the score is calculated:
10 (total scored)
45 (total possible score) x 100 = 22.2%

Minimum detectable change (95% confidence): 5 points or 10% points (change of less than this may be attributable error in the measurement).

**Interpretation of Scores**
Please circle the patient’s score:

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0% to 20%</td>
<td>Minimal disability: The patient can carry most living activities. Usually no treatment is indicated except for advice on lifting, sitting and exercise.</td>
</tr>
<tr>
<td>21% to 40%</td>
<td>Moderate disability: The patient experiences more pain and difficulty with sitting, lifting and standing. Travel and work in daily life are more difficult and they may be disabled for medical care. Sexual activity and sleeping are not grossly affected, but patient can usually be managed by conservative means.</td>
</tr>
<tr>
<td>41% to 60%</td>
<td>Severe disability: Pain remains the main problem in this group but activities of daily living are affected. These patients require a detailed investigation.</td>
</tr>
<tr>
<td>61% to 80%</td>
<td>Crippled: Back pain impinges on all aspects of the patient’s life. Positive intervention is required.</td>
</tr>
<tr>
<td>81% to 100%</td>
<td>These patients are either bed-bound or exaggerating their symptoms.</td>
</tr>
</tbody>
</table>

Score: ___24___ MODERATE

**Pain Severity Scale:**
Rate the severity of your pain by checking one box on the following scale.

| No Pain | 1 | 2 | 3 | X | 5 | 6 | 7 | 8 | 9 | 10 | Excruciating Pain |

# Pain Disability Index

<table>
<thead>
<tr>
<th>Category</th>
<th>Disability Rating</th>
<th>Worst Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain Disability Index</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intern: ___________ Doc #: ______ Patient: ___________ File #: ______ Date: ___________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

**Family/Home Responsibilities:** This category refers to activities of the home or family. It includes chores or duties performed around the home (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

No Disability __ 1 __ 2 __ 3 __ 4 __ 5 __ 6 __ 7 __ 8 __ 9 __ 10 __ Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.

No Disability __ 1 __ 2 __ 3 __ 4 __ 5 __ 6 __ 7 __ 8 __ 9 __ 10 __ Worst Disability

Social Activity: This category refers to activities which involve interaction with friends and acquaintances other than family members. It includes parties, theater, concerts, going out, and other social functions.

No Disability __ 1 __ 2 __ 3 __ 4 __ 5 __ 6 __ 7 __ 8 __ 9 __ 10 __ Worst Disability

Occupation: This category refers to activities that are part of one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.

No Disability __ 1 __ 2 __ 3 __ 4 __ 5 __ 6 __ 7 __ 8 __ 9 __ 10 __ Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

No Disability __ 1 __ 2 __ 3 __ 4 __ 5 __ 6 __ 7 __ 8 __ 9 __ 10 __ Worst Disability

Self-Care: This category includes activities, which involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed, etc.)

No Disability __ 1 __ 2 __ 3 __ 4 __ 5 __ 6 __ 7 __ 8 __ 9 __ 10 __ Worst Disability

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.

No Disability __ 1 __ 2 __ 3 __ 4 __ 5 __ 6 __ 7 __ 8 __ 9 __ 10 __ Worst Disability

Rev. 1/5/2017
## PAIN DISABILITY INDEX

**Intern:** Sample  
**Doc #:**  
**Patient:**  
**File #:**  
**Date:**  

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

**Family/Home Responsibilities:** This disability refers to activities of the home or family. It includes chores or duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

No Disability D__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__ Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.

No Disability D__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__ Worst Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

No Disability D__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__ Worst Disability

Occupation: This category refers to activities that are part of one’s job. This includes non-paying jobs as well, such as that of a housewife or volunteer.

No Disability D__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__ Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one’s sex life.

No Disability D__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__ Worst Disability

Self-Care: This category includes activities, which involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed, etc.)

No Disability D__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__ Worst Disability

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping, and breathing.

No Disability D__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__ Worst Disability

Rev. 1/5/2017
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Total Score: 24

Interpretation:
- minimal index: 0
- maximal index: 70
- The higher the index the greater the person's disability due to pain.

Instructions for how to incorporate OATS into the Narrative:

The disability score is a factor when considering the patient's functional prognosis. It is also incorporated into the goals of care by addressing what changes you expect by the next re-eval.

Example of how to incorporate OATS into the functional Prognosis: The functional prognosis for this patient is good due to the patient's Pain Disability Index score of 18 out of 70, their age (30 years old), active lifestyle and overall good health of the patient.

Example of how to incorporate the OATS in the Prognosis:
The goals of care are to reduce the Pain Disability Index score from 18 to 5 out of 70, specifically decreasing the patient's disability in recreation. The goal is for them to be able to golf an entire course without experiencing low back pain.

References:

Rev. 5/2017

Last page - Return to PDI in Section 2
MIGRAINE QUESTIONNAIRE (PedMIDAS)

Intern: ___________ Doc #: ___________ Patient: ___________ File #: ___________ Date: ___________

Headache Disability

The following questions try to assess how much the headaches are affecting day-to-day activity. Your answers should be based on the last three months. There are no “right” or “wrong” answers so please put down your best guess.

1. How many full school days of school were missed in the last 3 months due to headaches? ______

2. How many partial days of school were missed in the last 3 months due to headaches (or not include full days counted in the first question)? ______

3. How many days in the last 3 months did you function at less than half your ability to do school because of a headache (do not include days counted in questions one and two)? ______

4. How many days were you not able to do chores at home (i.e., chores, homework, etc.) due to your headache? ______

5. How many days did you not participate in regular activities due to headaches (i.e., play, go out, sports, etc.)? ______

6. How many days did you participate in these activities, but functioned at less than half your ability (do not include days counted in the 5th question)? ______

For Internal Scoring Only:

Total PedMIDAS Score ______

Headache Frequency (how many headaches in the last 3 months) ______

Headache Severity (on 0-10 pain scale) ______

Scoring The PedMIDAS is scored by summing the answers across the 6 questions. If a range is provided as an answer, either use the high end of the range or prompt for a single answer. The frequency and severity are not scored but can be used for clinical reference.

<table>
<thead>
<tr>
<th>PedMIDAS Score Range</th>
<th>Disability Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 10</td>
<td>Little to none</td>
</tr>
<tr>
<td>11 to 30</td>
<td>Mild</td>
</tr>
<tr>
<td>31 to 50</td>
<td>Moderate</td>
</tr>
<tr>
<td>Greater than 50</td>
<td>Severe</td>
</tr>
</tbody>
</table>

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PedMIDAS Continue
# MIGRAINE QUESTIONNAIRE (PedMIDAS)

<table>
<thead>
<tr>
<th>Intern: SAMPLE</th>
<th>Doc #:</th>
<th>Patient:</th>
<th>File #:</th>
<th>Date:</th>
</tr>
</thead>
</table>

**Headache Disability**

The following questions try to assess how much the headaches are affecting day-to-day activity. Your answers should be based on the last three months. There are no “right” or “wrong” answers so please put down your best guess.

1. How many full school days of school were missed in the last 3 months due to headaches? __8__

2. How many partial days of school were missed in the last 3 months due to headaches (do not include days counted in the first question)? __10__

3. How many days in the last 3 months did you function at less than half your ability in school because of a headache (do not include days counted in the first two questions)? __15__

4. How many days were you not able to do tasks (i.e., chores, homework, etc.) due to a headache? __15__

5. How many days did you not participate in other activities due to headaches (i.e., play, go out, sports, etc.)? __9__

6. How many days did you participate in these activities, but functioned at less than half your ability (do not include days counted in the 5th question)? __10__

---

**For Internal Scoring Only**

<table>
<thead>
<tr>
<th>Total PedMIDAS Score</th>
<th><strong>67</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache Frequency (how many headaches in the last 3 months)</td>
<td><strong>20</strong></td>
</tr>
<tr>
<td>Headache Severity (on 0-10 pain scale)</td>
<td><strong>8</strong></td>
</tr>
</tbody>
</table>

**Scoring**
The PedMIDAS is scored by summing the answers across the 6 questions. If a range is provided as an answer, either use the high end of the range or prompt for a single answer. The frequency and severity are not scored but can be used for clinical reference.

<table>
<thead>
<tr>
<th>PedMIDAS Score Range</th>
<th>Disability Grade</th>
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</thead>
<tbody>
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<td>0 to 10</td>
<td>Little to none</td>
</tr>
<tr>
<td>11 to 30</td>
<td>Mild</td>
</tr>
<tr>
<td>31 to 50</td>
<td>Moderate</td>
</tr>
<tr>
<td>Greater than 50</td>
<td>Severe</td>
</tr>
</tbody>
</table>

Last page - Return to PedMIDAS in Section 2
SHORT FORM MCGILL PAIN QUESTIONNAIRE AND PAIN DIAGRAM

Check the column to indicate the level of your pain for each word, or leave blank if it does not apply to you.

Please complete for your chief complaint ONLY

<table>
<thead>
<tr>
<th>Sensory Report</th>
<th>Mild (1)</th>
<th>Moderate (2)</th>
<th>Severe (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Throbbing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Shooting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Slabbing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Sharp</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Cramping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Gnatting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Hot-burning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Aching</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Heavy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Tender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Splitting</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Affective Report</th>
<th>Mild (1)</th>
<th>Moderate (2)</th>
<th>Severe (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 Tiring-Exhausting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Sickening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Fearful</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Cruel-Punishing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Indicate on this line how bad your pain is—at the left end of line means no pain at all, at right end means worst pain possible.

Visual Analog Scale (VAS)

<table>
<thead>
<tr>
<th>No Pain (1)</th>
<th>(10)</th>
<th>Worst Possible Pain</th>
</tr>
</thead>
</table>

For Internal Scoring Only

S / 33  A / 12  VAS / 10

Rev. 1/2017
**SHOR**T FORM MCGILL PAIN QUESTIONNAIRE AND PAIN DIAGRAM

Intern: ____________________  Doc #: ____________________  Patient: ____________________  File #: ____________________  Date: ____________________

Check the column to indicate the level of your pain for each word, or leave blank if it does not apply to you.

<table>
<thead>
<tr>
<th>Sensory Report</th>
<th>Mild (1)</th>
<th>Moderate (2)</th>
<th>Severe (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Throbbing</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Shooting</td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>3 Stabbing</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>4 Sharp</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>5 Cramping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Gnawing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Hot-burning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Aching</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>9 Heavy</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Tender</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>11 Splitting</td>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Affective Report</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12 Tiring-Exhausting</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Sidering</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Fearful</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 C wed-Punishing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mark or comment on the above figure where you have your pain or problems.

Indicate on this line how bad your pain is—at the left end of line means no pain at all, at right end means worst pain possible.

**Visual Analog Scale (VAS)**

<table>
<thead>
<tr>
<th>No Pain (1)</th>
<th></th>
<th>(10) Worst Possible Pain</th>
</tr>
</thead>
</table>

For Internal Scoring Only

<table>
<thead>
<tr>
<th>S</th>
<th>12 / 33</th>
<th>A</th>
<th>8 / 12</th>
<th>VAS</th>
<th>6 / 10</th>
</tr>
</thead>
</table>

Rev. 1/2017

Last page - Return to McGill in Section 2
TABLE OF CONTENTS

REASON FOR SEEKING CARE

Intern: __________ Doc #: ________ Patient: __________ File #: ________ Date: __________

Please describe the symptom(s) of your primary complaint:

______________________________________________________________________________

If you have more than one complaint, fill out an Additional Form for each complaint:

☐ I do not have any symptom(s).

ONSET
When did you start to have the symptom(s)?

How did the symptoms start? Can you identify a reason for the symptom(s)?

______________________________________________________________________________

If you have had these symptoms before, please describe:

______________________________________________________________________________

PROVOCATIVE:
What makes the symptoms worse or relieve the symptom(s)?

☐ Sitting ☐ Standing ☐ Moving ☐ Beverages ☐ Driving ☐ Coughing ☐ Sneezing ☐ Bearing Down
Other(s): ________________________________

PALLIATIVE:
What makes it feel better?

______________________________________________________________________________

QUALITY
Which best describes the quality of the symptom(s)? Please check that apply or describe:

☐ Dull Ache ☐ Sharp ☐ Deep ☐ Superficial ☐ Burning ☐ Stabbing ☐ Shooting ☐ Tingling ☐ Sharp ☐ Tight
Other: ________________________________

RADIATION
If the symptoms radiate, please describe where:

______________________________________________________________________________

SEVERITY
On a scale of 1 – 10, 10 being the worst pain, what is the level of pain:

_____ right now ______ at best ______ at worst ______ most of the time

TIMING:
How many days a week do you experience your symptom(s)? ________

On average, how long do you experience your symptom(s) in the course of a 24 hour day?

☐ Infrequent ☐ Occasionally ☐ Intermittently ☐ Frequently ☐ Constantly
(2 hrs of the day) (4 hrs of the day) (8 hrs of the day) (12 hrs of the day) (24 hrs of the day)

Does the pain wake you up? ☐ Yes ☐ No - If yes, does it keep you from sleeping? ☐ Yes ☐ No

Have you seen any other health care providers for this complaint? ☐ Yes ☐ No - If yes, please list they type of provider:

______________________________________________________________________________

Intern Notes:
______________________________________________________________________________

______________________________________________________________________________

Rev. 12/2017

Return to RFSC Section 2
PATIENT SURVEY

Indicate below, the location and type of pain that is current or ongoing.

Numbness === Pins and Needles o o o o Burning xxxx Stabbing $$$ Aching a a a

Patient Signature: ___________________________ Date: __________

(Please do not write above this line)

Intern Comments: __________________________________________
________________________________________________________________
________________________________________________________________

Rev. 03/2017

Return to Section 2
HISTORY OF ADDITIONAL COMPLAINT

Intern:_________ Doc #:_________ Patient:_________ File #:_________ Date:_________

Please describe the symptom(s) of your complaint:

Onset
When did you start to have the symptom(s)?

How did the symptom(s) start? Do you have a reason for the symptom(s)?

If you have had these symptom(s) before, please describe:

Provocative
What makes the symptoms worse (check all that apply)?

☐ Sitting ☐ Standing ☐ Moving ☐ Bending forward ☐ Driving ☐ Coughing ☐ Sneezing ☐ Bearing Down

Other(s):_________

Palliative
What makes it feel better?

Quality
What best describes the quality of the symptom(s)? Please check all that apply or describe:

☐ Dull ☐ Acute ☐ Sharp ☐ Deep ☐ Superficial ☐ Burning ☐ Numbing ☐ Stinging ☐ Tingling ☐ Stiff ☐ Tight

Other:

Radiation
If the symptoms radiate, please describe where:

Severity
On a scale of 1 – 10, 10 being the worst pain, what is the level of pain right now? _______ at best _______ at worst _______ most of the time _______

Timing
How many days a week do you experience your symptom(s)?

On average, how long do you experience your symptom(s) in the course of a 16 hour day?

☐ Infrequent ☐ Occasionally ☐ Intermittently ☐ Frequently ☐ Constantly
(2 hrs of the day) (4 hrs of the day) (8 hrs of the day) (12 hrs of the day) (18 hrs of the day)

Does the pain wake you up? ☐ Yes ☐ No - If yes, does it keep you from sleeping? ☐ Yes ☐ No

Have you seen any other health care providers for this complaint? ☐ Yes ☐ No - If yes, please list they type of provider:

Intern Notes:

__________________________________________________________

__________________________________________________________

Rev. 1/2017
# HEADACHE HISTORY

**Interm:** __________  **Doc #:** __________  **Patient:** __________  **File #:** __________  **Date:** __________

**When was your last headache?**  
**How often do you get headaches?**  
**How long do they typically last?**

**When did you first start getting headaches?**  
**Are they more intense or frequent?**  
**[ ] Yes  [ ] No  
**Do you have symptoms that indicate you will get one?**  
**[ ] Yes  [ ] No  
**What are they?**

**SPECIFIC LOCATION:**  
[ ] Frontal  [ ] Temporal  [ ] Occipital  [ ] Other__________________________  
[ ] Bilateral  [ ] Left  [ ] Right  [ ] Radiating from__________________________ to__________________________

**CHARACTER OF HEADACHE**  
[ ] Sharp/Slabbing  [ ] Dull Ache  [ ] Throbbing/Pounding  [ ] Deep  [ ] Superficial

**WHAT MAKES YOUR HEADACHES:**  
**PROVOCATIVE (WORSE)**

**PALLIATIVE (BETTER)**

**SEVERITY of typical H sibling:** at best__________/10; most of the time__________/10

**CONCURRENT SYMPTOMS:**

- **Do you have any of the following?**  
  [ ] Jaw Tension  [ ] Meningeal pain  [ ] Neck pain  
  [ ] Do you wear glasses?**  
  [ ] Yes  [ ] No  
  **Date of last eye exam:__________________________

- **Are there any symptoms that occur once the headache is present?**  
  [ ] No  [ ] Yes  
  [ ] Nausea  [ ] Vomiting  [ ] Lethargy/Fatigue  [ ] Photosensitivity  
  [ ] Visual Disturbance  [ ] Muscle Weakness  [ ] Tinnitus/Ears & Neck  [ ] Other

*Please describe in detail:

**DO YOU CURRENTLY HAVE A HEADACHE?**  
**[ ] Yes  [ ] No**

**When did current HA begin?**

[ ] Any traumatic event?  
**If no, what activity were you doing when the headache began?**

**What activity(ies) 4-8 hours prior?**  
**What activity(ies) 24 hours prior?**

[ ] Have you had this type of headache before?  
[ ] No  [ ] Yes  
**SPECIFIC LOCATION:**  
[ ] Frontal  [ ] Temporal  [ ] Occipital  [ ] Other__________________________  
[ ] Bilateral  [ ] Left  [ ] Right  [ ] Radiating from__________________________ to__________________________

**CHARACTER OF HEADACHE**  
[ ] Sharp/Slabbing  [ ] Dull Ache  [ ] Throbbing/Pounding  [ ] Deep  [ ] Superficial

**PROVOCATIVE (WORSE)**

**PALLIATIVE (BETTER)**

**SEVERITY OF CURRENT HEADACHE? (VAS)__________/10**

**FEMALE PATIENTS**

**Are your headaches associated with your menses?**  
[ ] No  [ ] Yes

**Are you on birth control pills or hormone therapy?**  
[ ] No  [ ] Yes  
**How long?__________ Type__________

Rev. 1/2017
## INTERN COMPLETE ONLY IF NEW COMPLAINT ONLY

<table>
<thead>
<tr>
<th>Required Regional Exams:</th>
<th>Required OATs:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Intern Faculty</td>
</tr>
<tr>
<td>Cervical/TOS Exam</td>
<td></td>
</tr>
<tr>
<td>Thoracic Spine Exam</td>
<td></td>
</tr>
<tr>
<td>Low Back/Pelvis Exam</td>
<td></td>
</tr>
<tr>
<td>Visual Exam</td>
<td></td>
</tr>
<tr>
<td>Special Procedures</td>
<td></td>
</tr>
<tr>
<td>Cranial Nerve Exam</td>
<td></td>
</tr>
<tr>
<td>H.E.E.N.T. Exam</td>
<td></td>
</tr>
<tr>
<td>Wrist/Hand Exam</td>
<td></td>
</tr>
</tbody>
</table>

### New Complaint

<table>
<thead>
<tr>
<th>Complaint withModifiers</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Possible Subluxationareas</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Most LikelyConditions</th>
</tr>
</thead>
</table>

### Differential Diagnosis

<table>
<thead>
<tr>
<th>Co-morbidities</th>
</tr>
</thead>
</table>

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**By my signature below, I acknowledge that I have reviewed new complaint completely.**

Intern Signature: ___________________________ Date: _______________

Faculty Signature: ___________________________ Date: _______________
# WELLNESS QUESTIONNAIRE

**Intern:** __________________________  **Doc #:** ____________  **Patient:** __________________________  **File:** __________________________  **Date:** __________________________

Please answer the following questions on a scale of 1-10, 10 being the best:

- General State of Well-being: ______
- General Outlook and Attitude: ______

Please answer the following question on a scale of 1-10, 10 being the most stress:

- Average Level of Stress: ______
- In the past 30 days, how many times have you felt healthy and full of energy? ______
- In the past 30 days, how many times were you physically not good? ______

What is your occupation? ____________________________________________________________

Please describe your work duties: _______________________________________________________

How many hours/week do you work? ______  Are you content with your work? No ___ Yes ___

If not, please describe: ______________________________________________________________

What other interests/hobbies do you engage in? __________________________________________

Diet and Nutrition: Do you currently follow any of the following special diets or nutritional programs? Circle all that apply:

Vegetarian  Vegan  Allergy Elimination  Carb High Protein  Blood Type  Low Sodium  No Dairy  No Wheat  Gluten Free  Other: __________________________

- How many of each 1/2 cup serving/day of fruits and vegetables: ______
- How many of each per day (on average) sweets: ______
- How many glasses of water do you drink per day? ______
- How many meals do you eat out per week? Please circle: 0 1-3 4-6 >5 meals per week
- Do you have sensitivities/Intolerances to certain foods? No ___ Yes ___  If yes, list food and symptoms: ____________________________________________________________

- Do you drink Alcohol? No ___ Yes ___

If yes: How many alcoholic beverages do you drink in a week? Please circle:

(1 drink = 5 ounces of wine, 12 ounces of beer, or 1.5 ounces of hard liquor)

- None 1-3 4-6 >10

- Do you drink caffeine? No ___ Yes ___  How often: ______  How many cups/day: ______

Circle all that apply:

Coffee  Tea  Green Tea  Energy Drinks  Sodas

- Do you use tobacco products? No ___ Yes ___  If so, Number of years: ______

- What type? Circle all that apply and note amount per day:

  Cigarettes: ______  smokeless pipe: ______  cigar: ______  e-cigarette: ______

- Do you exercise? No ___ Yes ___  If so, what kind? Circle all that apply:

  Aerobic/Aerobic Strength/Resistance Flexibility/Stretching Balance  Sports/Leisure  Other: ______

- How many hours of sleep do you get each night? ______  Do you have problems falling asleep? Yes ___ No ___

- Do you have problems staying asleep? Yes ___ No ___  Is it stressful? Yes ___ No ___

- Other concerns?: _________________________________________________________________

- Please circle all that apply: Do you currently experience stress, anxiety, depression, or any of the above?

- Are you currently under treatment for it? No ___ Yes ___

- If yes, please describe treatment: __________________________________________________

- Do you feel the treatment is effective: ______________________________________________

**Patient Signature:** __________________________  **Date:** __________________________

**Intern Notes:** __________________________  __________________________

__________________________  __________________________

---

Rev. 1/2017

**Return to Section 2**

---

Health Center Manual: Section 4  136
TABLE OF CONTENTS

REVIEW OF SYSTEMS

<table>
<thead>
<tr>
<th>System</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury/trauma</td>
<td>P C Back injury, P C Head injury, P C Soft tissue injury, P C Fall injury, P C Car Vehicle Injury</td>
</tr>
<tr>
<td>General history</td>
<td>P C Anemia, P C Bleeding/bruising, P C Skin lesions/scars, P C Cancer, P C Allergies/Sinusitis, P C Chills/Fever, P C Loss of appetite</td>
</tr>
<tr>
<td>Eye/Ear/Nose/Throat</td>
<td>P C Eye/Visual problems, P C Hearing difficulty, P C Ringing in ears, P C Change in smell, P C Frequent ear infections, P C Nosebleeds</td>
</tr>
<tr>
<td>Lung/Respiratory</td>
<td>P C Asthma/Wheezing, P C Coughing up blood, P C Cough, P C Pneumonia/infections, P C Colds/fever, P C Dental problems</td>
</tr>
<tr>
<td>Heart/Cardiovascular</td>
<td>P C Heart disease/surgery, P C Heart murmur, P C High/low blood pressure, P C Polyphylusion, P C Shock</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>P C Abdominal pain/swelling, P C Jaundice/liver disease, P C Hemorrhoids, P C Constipation/diarrhea, P C Racial bleeding, P C Gallbladder disease/Stone</td>
</tr>
<tr>
<td>Endocrine</td>
<td>P C Cold/heat intolerance, P C Excessive hunger/thirst, P C Unusual hair loss/growth, P C Diabetes, P C Hormone therapy, P C Voice changes</td>
</tr>
<tr>
<td>Nervous system</td>
<td>P C Dizziness/Fainting, P C Loss of memory, P C Slurred speech, P C Headache, P C Numbness, P C Stroke, P C Loss of consciousness, P C Paralysis</td>
</tr>
</tbody>
</table>

ROS continued
# REVIEW OF SYSTEMS

**Urinary System**
- P C Chronic bladder infections
- P C Frequent/painful urination
- P C Pelvic/Gynec pain/mass
- P C Difficulty starting/holding
- P C Kidney disease
- P C Blood in urine

**Female History**
- P C Abnormal vaginal bleeding/discharge
- P C Cramps/pelvic pain
- P C Hispanic/menstrual cycle
- P C Breast lump/mass
- P C Frequent yeast infection

**Concerns about your reproductive health:**
(Circle Y for Yes, N for No)
- Y N I am pregnant
- Y N I do have osteoporosis/patia
- Y N I am in menopause

If you have been pregnant in the past, please fill in the appropriate information below.
- _____ Number of complicated pregnancies
- _____ Number of uncomplicated pregnancies
- _____ Number of hormone pregnancies
- _____ Number of vaginal deliveries
- _____ Number of Caesarean sections
- _____ Number of miscarriages
- Last PAP date: Normal: Y N
- Last mammogram date: Normal: Y N

**Male History**
- P C Burning/frequent urination
- P C Hispanic/pelvic pain
- P C Urine retention
- P C Erectile dysfunction
- P C Bladder disease
- P C STD/STI
- P C Testicular mass/pain
- P C Male PTA/PSA date

**Concerns about your reproductive health:**

**Family History:** Please write who the relation is and how old they were when had the disease.
- P C Alzheimers
- P C Backache
- P C Breast
- P C Cancer
- P C Heart disease
- P C Headache
- P C High blood pressure
- P C Depression
- P C Dementia
- P C Diabetes Type 1/Type 2

**Medical History**
- Date of last physical exam and reason:
- Date of last X-ray taken and reason:
- Date of last MRI/CT taken and reason:

**Bone Density DEXA:**
- Have you ever experienced an aortic dissection aneurism? Y N
- Is there a family history of aortic dissection aneurism? Y N
- Is there a family history of Collagen diseases (i.e. Marfan’s Syndrome)? Y N
- Have you had disabling neck or arm pain, headache or concussion within past 2 months? Y N

Please list all current medications and supplements taken. Include frequency and dosage if known.
1. 
2. 
3. 
4. 

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ROS continued
TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>ADDITIONAL NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intern: __________________</td>
</tr>
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CASE HISTORY – DIAGNOSIS WORKSHEET

Intern: _____________________  Doctor: _____________________  Patient: _____________________  File #: _____________________  Date: _____________________

Review of Systems: Summarize significant findings:


Required Regional Exams:  
- Cervical/TOS Exam
- Thoracic Spine Exam
- Low Back/Pelvis Exam
- Visceral Exam
- Special Procedures
- Cranial Nerve Ex
- H.E.E.N.T. Exam

- Record should be ordered from previous provider:


Chief Complaint  
Complaint #2  
Complaint #3

Possible Sublocation areas

Most Likely Condition(s)

Differential Diagnosis

Co-morbidities

Use additional page if more than 3 complaints. Keep same format.

By my signature below, I acknowledge that I have reviewed all systems completely.

Intern Signature: _____________________  Date: _____________________

Faculty Signature: _____________________  Date: _____________________

Rev. 03/2017

Return to Case History Section 2
### HISTORY OF NEW COMPLAINT

<table>
<thead>
<tr>
<th>Item:</th>
<th>Doc #:</th>
<th>Patient:</th>
<th>File #:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Please describe the symptom(s) of your complaint:


**ONSET**

When did you start to have the symptom(s)?

How did the symptoms start? Can you identify a reason for the symptom(s)?


If you have had these symptoms before, please describe:


**PROVOCATIVE**

What makes the symptoms worse (check all that apply):

- [ ] Sitting
- [ ] Standing
- [ ] Moving
- [ ] Bending over
- [ ] Riding
- [ ] Coughing
- [ ] Sneezing
- [ ] Bearing Down
- [ ] Others:

**PALLIATIVE**

What makes it feel better?


**QUALITY**

What best describes the quality of the symptoms? Please check all that apply or describe:

- [ ] Dull
- [ ] Ache
- [ ] Sharp
- [ ] Deep
- [ ] Superficial
- [ ] Burning
- [ ] Numbness
- [ ] Stinging
- [ ] Tingling
- [ ] Stiff
- [ ] Tight
- [ ] Others:

**RADIATION**

If the symptoms radiate, please describe where:


**SEVERITY**

On a scale of 1 – 10, 10 being the worst pain, what is the level of pain:

right now ___ at best ___ at worst ___ most of the time

**TIMING**

How many days a week do you experience your symptom(s)?

On average, how long do you experience your symptom(s) in the course of a 16 hour day?

- [ ] Infrequent
- [ ] Occasionally
- [ ] Intermittently
- [ ] Frequently
- [ ] Constantly

(2 hrs of the day) (4 hrs of the day) (8 hrs of the day) (12 hrs of the day) (16 hrs of the day)

Does the pain wake you up?  □ Yes □ No - If yes, does it keep you from sleeping? □ Yes □ No

Have you seen any other health care providers for this complaint? □ Yes □ No - If yes, please list type of provider:


Intern Notes:


Rev. 1/2017
# HISTORY OF NEW COMPLAINT

## Required Regional Exams:
- Cervical/Thoracic Exam
- Thoracic Spine Exam
- Low Back/Pelvis Exam
- Low Extremity Exam
- Vestibular Exam
- Special Procedures
- Cranial Nerve Exam
- H.E.E.N.T. Exam

## Required CATs:
- McGill
- DASH
- HDI
- LEFS
- MIDAS
- PHQ-8
- MIDAS-Peds
- GAD-7
- NDI
- RM-LB
- PDI

<table>
<thead>
<tr>
<th>Complaint with Modifiers</th>
<th>New Complaint</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Possible Sublocation areas</th>
<th>Most Likely Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Differential Diagnosis</th>
<th>Co-morbidities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

By my signature below, I acknowledge that I have reviewed new complaint **completely**.

Intern Signature: __________________________ Date: __________

Faculty Signature: __________________________ Date: __________

Rev. 1/2017
### SUMMARY OF FINDINGS AND IMAGING REQUEST

**Interc.:** 

**Doc.:** 

**Patient:** 

**File #:** 

**Date:** 

**Advisor:** 

**Patient's Date of Birth:** 

**Gender:** M F

**Patient Complaints, include type, location, and duration:** 

**Previous X-rays Taken and Reasons for Radiation Therapy:** 

**Red Flags:** X-ray of the region listed is required in all the following cases; Circle ALL that apply:

1. Acute trauma with immediate loss of range of motion and pinpoint tenderness, date/region:
2. Patient history of cancer at this level, date/region:
3. Clinical suspicion of neoplasm, bone infection list region:
4. Evidence of cauda equina
5. Inability to bear weight on extremity:
6. History of spinal and/or joint surgery, reason to be adjusted, date/region:

Check if no Red Flags: If no red flags are present

**Check ALL that apply:**

<table>
<thead>
<tr>
<th>Red Flags</th>
<th>X-rays may be required in the following cases based on clinical judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinal pain</td>
<td>History of spine injury to be adjusted, Date/Description in notes below</td>
</tr>
<tr>
<td>Neurological symptoms</td>
<td>History of spinal pain</td>
</tr>
<tr>
<td>Current skin conditions</td>
<td>Current skin conditions</td>
</tr>
<tr>
<td>Radiological findings</td>
<td>Radiological findings: description</td>
</tr>
</tbody>
</table>

**X-rays may be required for biomechanical assessment, as in the following criteria:**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>X-rays may be required for biomechanical assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased range of motion</td>
<td>X-rays may be required for biomechanical assessment</td>
</tr>
<tr>
<td>Decreased range of motion</td>
<td>X-rays may be required for biomechanical assessment</td>
</tr>
<tr>
<td>Spinal tenderness</td>
<td>X-rays may be required for biomechanical assessment</td>
</tr>
<tr>
<td>Abnormal posture</td>
<td>X-rays may be required for biomechanical assessment</td>
</tr>
<tr>
<td>Spinal tenderness upon palpation</td>
<td>X-rays may be required for biomechanical assessment</td>
</tr>
<tr>
<td>To evaluate biomechanical effects of care (for post-films)</td>
<td></td>
</tr>
</tbody>
</table>

**Faculty:** Initial box for x-rays then write extremity in notes

<table>
<thead>
<tr>
<th>Extremity</th>
<th>Nucka w/APLC</th>
<th>Toggle 3y cervical/brachial posterior</th>
</tr>
</thead>
</table>

**Additional x-rays:** DACBR requested views/follow up:

**Notes:**

**Faculty Signature** 

**Date** 

**Imaging Faculty, Views** 

**Date** 

**For female patients:** There is no possibility I may be pregnant:

**Signature** 

**Date**

**Lab work required?** NO CHYes If yes, please complete lab request and requisition forms.

---

Return to Summary of Findings - Section 2

Return to imaging requisition - Section 5
# X-RAY NARRATIVE

**Intervening Doctor:** Patient: File #: Date:

Films Dated: Dated at Location or By:

Views Taken: Cervical Spine: Thoracic Spine: Lumbar Spine: Extremity:

<table>
<thead>
<tr>
<th>Cervical Spine</th>
<th>Lumbar Spine</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADI</td>
<td>millimeters</td>
</tr>
<tr>
<td>Stress Lines intersect at:</td>
<td>Sacroiliac Angle: degrees</td>
</tr>
<tr>
<td>Grav Line falls:</td>
<td>Grav Line falls at:</td>
</tr>
<tr>
<td>Lat Curve: (degrees)</td>
<td>Lat Curve: (degrees)</td>
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<tr>
<td>AP Curve:</td>
<td>AP Curve:</td>
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<tr>
<td>George’s Line:</td>
<td>Listings:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Thoracic Spine</th>
<th>Extremity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lat Curve:</td>
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<td>AP Curve:</td>
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</table>

X-Ray Narrative:

A:  

B:  

C:  

S:  

X-ray Impressions:  

Technical Assessment:  

Faculty Signature: Date:  

Rev. 08/2018  

---

**TABLE OF CONTENTS**
TABLE OF CONTENTS

Re-Evaluation Patient Survey and Examination

---

Re-Evaluation continued
# RE-EVALUATION PATIENT SURVEY AND EXAMINATION

**Date of last exam:**

<table>
<thead>
<tr>
<th>Inspection/Posture</th>
<th>Previous Objective Findings</th>
<th>Current Objective Findings</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Palpation</th>
<th>CERVICAL Pain Location</th>
<th>LUMBAR Pain Location</th>
<th>CERVICAL Pain Location</th>
<th>LUMBAR Pain Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flex:</td>
<td>Y</td>
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<td>Flex:</td>
<td>Y</td>
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<td>Ext:</td>
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<td>L.F.:</td>
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<td>L.L.:</td>
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<tbody>
<tr>
<td>Orthopedic and peripheral examination of area of complaint.</td>
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<td>Cervical indicated</td>
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</table>

<table>
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<th>Extremities</th>
<th>Cervical indicated</th>
<th>Cervical indicated</th>
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</thead>
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<tr>
<td>Lededalities examined</td>
<td>Cervical indicated</td>
<td>Cervical indicated</td>
</tr>
</tbody>
</table>

| HEBIT/Visceral Cranial Nerves/ TND | Cervical indicated | Cervical indicated |

<table>
<thead>
<tr>
<th>Vital Signs</th>
<th></th>
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<tbody>
<tr>
<td>Height:</td>
<td>ft. in.</td>
<td>Pulse Rate: L. / R. /</td>
</tr>
<tr>
<td>Resp. Rate:</td>
<td>1/min.</td>
<td>Temp. F.</td>
</tr>
</tbody>
</table>

**Faculty Signature:**

**Date:**

---

Last page - Return to RE-EVAL in Section 2
LAB REQUEST

Intern: ___________________________ Doc #: ___________________________ Date: ______________ 

Patient Name: ___________________________ DOB: ___________________________ File #: ___________________________

R = Requested by Intern  A = Approved by Faculty

<table>
<thead>
<tr>
<th>Panel</th>
<th>R</th>
<th>A</th>
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Clinical Justification:

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Diagnosis Codes: ___________________________

Faculty Signature: ___________________________ Date: ______________

LAB NARRATIVE

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____________________________________________________________________________________

____________________________________________________________________________________

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____________________________________________________________________________________

____________________________________________________________________________________

Faculty Signature: ___________________________ Date: ______________

Rev. 08/2016

Return to Lab Request in Section 2
PATIENT REFERRAL

Life West Health Center
25001 Industrial Boulevard
Hayward, California 94545
(510) 780-4567

Please Print:
Patient Name: ___________________________ Date: __________________
Date of Birth: __________________
File Number: __________________
Intern Name: __________________

This is to certify that I have been examined at my x-rays, laboratory tests and/or physical examinations reveal:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

I understand that I should seek another medical opinion for evaluation.

Patient or Guardian Signature: ______________________________
Intern Signature: ______________________________
Faculty Signature: ______________________________

A copy of patient records will be provided at no charge, with signed authorization.
Original: Patient
Copy: Patient File, Compliance Officer, Faculty Advisor: ______________________________

Rev. 09/2010

Return to Patient Referral in Section 2
PEDiatric TAKE HOME QUESTIONNAIRE
BIRTH TO 1 YEAR OF AGE

Intern: ___________________ Doc #: _______ Patient: ___________________ File #: __________ Date: __________

Please fill out and bring to the Health Center. If you require additional paper to more accurately fill out the questionnaire, please attach a separate sheet of paper and provide all details as necessary.

Reason for seeking care for your child. Please check all that apply:
☐ Wellness and Health Improvement ☐ Colic ☐ Digestive ☐ Ear problems ☐ Respiratory
☐ Sleep ☐ Other

The Birth
☐ Normal ☐ Breech ☐ Forceps/vent ☐ Vacuum extraction
☐ Home Birth ☐ Hospital ☐ Birthing Center ☐ Premature Delivery ☐ Congenital Defects
☐ Cesarean If yes, for what reason was the cesarean performed?

Labor/Delivery Issues

The Pregnancy
☐ Medications/Drugs ☐ Smoked Cigarettes ☐ Alcohol Consumption
☐ Caffeine

Any diagnosed illnesses/injuries or hospitalizations?

Did you have: ☐ Prenatal care/classes ☐ Chronic illness ☐ Vitamins

Neonatal History: Please check any of the following issues the child had at birth.
☐ Medications ☐ Surgery ☐ Artificial Feeding ☐ Vitamin K ☐ Hepatitis B Vaccine
☐ Breathing ☐ Coloring ☐ Crying ☐ Choking ☐ Colicky ☐ Nursing ☐ Sleeping
☐ Jaundice

Please check if the child has received any of the following:
☐ Breast milk ☐ Commercial formula ☐ Cow’s milk ☐ Other milk ☐ Solid Foods ☐ Sweets
☐ Fruit juice ☐ Vegetable juice ☐ Vitamins

Immunizations and Medical History

Please list any immunizations that the patient has received along with the date and any reactions observed.

Name of Pediatrician and date of last exam:

Please list any illnesses or traumas the patient has had:

Is the patient on any medications? If so, Please list:
# PEDIATRIC TAKE HOME QUESTIONNAIRE

**BIRTH TO 1 YEAR OF AGE**

Previous Medical History: Please list any of the following the child has had:
- Allergies/ Asthma
- Anemia
- Ear problems
- Broken bones
- Earaches
- Colds/Flu
- Constipation
- Convulsions
- Diarrhea
- Digestive problems
- Frequent infections
- Heart condition
- Jaundice
- Joint problems
- Leg problems
- Muscle jerks
- Psoriasis
- Poor Appetite
- Sinus
- Skin problems

Other

Family History: Please check if any blood relative to the child had any of the following diseases and mark accordingly, noting who the relative is.

- Cancer, What kind?
- Diabetes
- Heart
- High Blood Pressure
- Kidney failure
- Mental
- Scoliosis
- Stroke
- Other

Family, Environment and Community

Do you or anyone in the home smoke? □Yes □No
Do you have a healthy diet? □Yes □No
Do you exercise regularly? □Yes □No
Do you sleep well at night? □Yes □No
Is your life stressful? □Yes □No
Is your child's life stressful? □Yes □No If yes, please explain

Would you say your child's health is:
- Excellent
- Very Good
- Good
- Fair
- Poor

Are there any other health concerns or problems that you would like to address? If so, please explain:

Parent or Guardian Signature

Date

---

Last page - Return to Pedi Form in Section 2
**12 POINT EVALUATION**

Name: ___________________________  Phone Number: ___________________________  Email: ___________________________

I give my permission for Life Chiropractic College West and all students, faculty and affiliates to perform a preliminary spinal screening today. I am aware that my personal health history will be reviewed in public at this time. I release all students, faculty and affiliates of Life Chiropractic College West from any liability resulting from any loss or damages that I may sustain during this screening process.

Initials: ________________________

For Internal Scoring Only

<table>
<thead>
<tr>
<th>1. Gait</th>
<th>Unremarkable</th>
<th>Limp</th>
<th>Uses support</th>
<th>Unable to walk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tandem Walk</td>
<td>Abnormal Describe</td>
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<tr>
<td>Heel Walk</td>
<td>Abnormal Describe</td>
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<td>Toe Walk</td>
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**Postural Analysis:**

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</table>

5. Head tilt  
6. Shoulder tilt  
7. Pelvis tilt

**Leg Checks:**

<table>
<thead>
<tr>
<th>Spine: CL Short</th>
<th>OR Short</th>
<th>CLAD</th>
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**Internal Notes:**

___________________________________________________________

___________________________________________________________

Based upon these findings we ___ do ___ do not recommend Chiropractic care for you.

Intern Signature: ___________________________  Faculty Signature: ___________________________

These findings have been explained to me: Patient Signature: ___________________________  Date: ___________________________

Appointment scheduled? ___Yes ___No  Date/Time of appointment: ___________________________

Life West Health Center  25881 Industrial Blvd. Hayward CA.

510-780-4567

Rev 03/22/17

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**12 Point Continue**
**12 POINT EVALUATION**

Name: ___________________________ Phone Number: ___________________________ Email: ___________________________

I give my permission for Life Chiropractic College West and all students, faculty and affiliates to perform a preliminary spinal screening today. I am aware that my personal health history will be reviewed in public at this time. I release all students, faculty and affiliates of Life Chiropractic College West from any liability resulting from any loss or damages that I may sustain during this screening process.

Initials: ___________________________

For Internal Scoring Only

1. Gait
   - [ ] Unremarkable
   - [ ] Limp
   - [ ] Uses support
   - [ ] Unable to walk

2. Tandem Walk
   - [ ] Abnormal Described
   - [ ] QNAD

3. Heel Walk
   - [ ] Abnormal Described
   - [ ] QNAD

4. Toe Walk
   - [ ] Abnormal Described
   - [ ] QNAD

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Postural Analysis:

8. Curvature

- [ ] Head tilt
- [ ] Shoulder tilt
- [ ] Pelvis tilt

Leg Checks:

- [ ] Spine: DBL Long OR Short
- [ ] Pronation: DBL Long OR Short
- [ ] Dorsiflexion: QNAD
- [ ] Right: QNAD
- [ ] Left: QNAD

Int. Notes:

______________________________
______________________________

Based upon these findings we: [ ] Do [ ] Do not recommend Chiropractic care for you.

Intern Signature: ___________________________ Faculty Signature: ___________________________

These findings have been explained to me: Patient Signature: ___________________________ Date: ___________________________

Appointment scheduled? [ ] Yes [ ] No Date/time of appointment ____________________________________

Life West Health Center 25081 Industrial Blvd, Hayward CA 510-780-4567

Rev 01/23/17

Last page - Return to 12 Point Eval in Section 2
# GIVE US A GRADE

We would appreciate if you would answer the following questions for our ongoing patient survey. We will be using the information from these surveys to improve patient services. Please feel free to include comments.

For questions asking for a letter grade please use the following guidelines:
A = Excellent, best grade possible 90-100%  | B = Better than average 80-90%  | C = Average performance 70-80%
D = Below average/ poor 60-70%  | F = Unacceptable performance less than 60%

1. Satisfaction with the Health Center Facility
   - Health Center Hours
   - Overall appearance of facility
   - Fee Schedule
     | A | B | C | D | F |
     |---|---|---|---|---|

2. Satisfaction with the Waiting Time in the Health Center
   - How long did you wait at the front desk to check in?
     - A. 0-5 min.  B. 5-10 min.  C. 10-15 min.  D. 15-20 min.  E. over 20 min.  F. N/A
   - How long did you wait in the waiting room for your intern?
     - A. 0-5 min.  B. 5-10 min.  C. 10-15 min.  D. 15-20 min.  E. over 20 min.  F. N/A
   - How long did you wait for faculty/observers?
     - A. 0-5 min.  B. 5-10 min.  C. 10-15 min.  D. 15-20 min.  E. over 20 min.  F. N/A
   - How long did you wait for the cashier?
     - A. 0-5 min.  B. 5-10 min.  C. 10-15 min.  D. 15-20 min.  E. over 20 min.  F. N/A

3. Satisfaction with intern in charge of your care
   - Availability for appointments
   - Professional appearance
   - Overall satisfaction with intern
     | A | B | C | D | F |
     |---|---|---|---|---|

4. Satisfaction with the explanation of your care and care plan
   - Explanation of what is Chiropractic?
     | A | B | C | D | F |
   - Explanation of what is a subluxation?
     | A | B | C | D | F |
   - Explanation of how Chiropractic can benefit you
     | A | B | C | D | F |
   - Explanation of how long it will take
     | A | B | C | D | F |
   - Teaching you how you can actively participate in bettering your health
     | A | B | C | D | F |

5. Satisfaction with Faculty Doctors
   - Accessibility
     | A | B | C | D | F |
   - Adequately supervised my care
     | A | B | C | D | F |
   - Professional appearance
     | A | B | C | D | F |

6. Satisfaction with our front desk and cashier staff
   - Friendly helpful
     | A | B | C | D | F |
   - Answering your questions
     | A | B | C | D | F |
   - Respected your privacy
     | A | B | C | D | F |
   - Professional appearance
     | A | B | C | D | F |

How many people have you referred to the Health Center? _______

Comments:______________________________________________________________

______________________________________________________________

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Rev. 05/2016

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Return to Give Us a Grade  Section 2
AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize: ______________________________________ To disclose to: Life Chiropractic College West Health Center

____________________________________________________

Records and information pertaining to:

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Address</th>
<th>Date of Birth</th>
<th>Telephone #</th>
</tr>
</thead>
</table>

- This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here.

- This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosure of protected health information has occurred in reliance upon this authorization.

- I understand that the recipient may not lawfully use or disclose the health information unless other authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY RECORDS: [ ] Medical Information [ ] Imaging or Laboratory Tests

Description of the record(s) or specific region of x-rays and date of x-rays to be disclosed: ____________________________

The recipient may use the health information authorized on this form for the following purpose(s):

__________________________________________________________________________________________________________

I understand that I have the right to receive a copy of this authorization upon my request. I understand that LCCW will not condition my treatment based upon my providing or refusing to sign this authorization.

Date: ______________ Signature: _________________________ Self/Parent/Guardian

Dec. 5/2014

Table of Contents

Return to HIPAA Section 3

Return to Xray Records request Section 5
Re-evaluation with a New Complaint Narrative
This is written in narrative form. Please do not use lists to compare the complaints or the exam findings. Use complete sentences.

History of the New Complaint
Introduce the patient and time of onset, severity frequency and duration and details of the new complaint.

Previous Complaints with results of
Discuss progress for each complaint based on subjective findings of severity, frequency and duration of the symptoms. (What is better? How much better? Has it resolved? Is it unchanged? Is anything worse? If the symptoms are worse, explain why you think this is so.) Did you meet your goals? If not, why not?

Wellness questionnaire
Compare the wellness form from the previous examination of the patient has followed any of the previous recommendations.

Updated examination findings
Compare changes (from prior exam) in inspection, palpation, range of motion (including subluxation findings), ROM and ortho/neuro findings, grouped by body part. Indicate meaning of findings. Include any findings that went from positive to negative.

Clinical Impression of the New Complaint
This section is based on the initial clinical impression and the examination/essay findings that lead to your final diagnosis for the New Chief Complaint.

List the diagnosis from your initial clinical impression. Explain the particular condition(s) causing the patient’s complaint including information from the history, examination and x-ray findings (if applicable).

The patient’s diagnosis includes the following:
- Write complaint with applicable modifiers
  - Subluxations of list level(s) of area of chief complaint
  - Write condition causing patient’s complaint. This condition was considered due to include relevant information from the patient’s history. It was confirmed by include information obtained from the exam and pertinent radiographic imaging.
  - List structural diagnosis(es) from x-rays that pertain to chief complaint i.e., DDD L5-S1
  - List functional diagnosis(es) i.e., Aberrant posture—lower cross
  - List soft tissue diagnosis(es) for region if applicable

Received 7/2/16
Re-evaluation Narrative
This is written in narrative form. Please do not use lists to compare the complaints or the
exam findings, use complete sentences.

Previous Complaints with recent update
Discuss progress for each complaint based on subjective findings of severity, frequency and
duration of the symptoms. What is better? How much better? Has it resolved? Is it
unchanged? Is anything worse? (If symptoms are worse, explain why you think this is so.)
Did you meet your goals? If not, why not?

Updated Wellness questionnaire
Compare the wellness form from the prior exam and see if the patient has followed any of
the previous recommendations.

Updated examination findings
Compare changes (from prior exam) in inspection, patient’s findings (including subluxation
findings), ROM and ortho/neuro findings, grouped by region. Indicate meaning of findings.
Include any findings that went from positive to negative.

Updated Clinical Impression
Diagnosis: (Copy from prior narrative and update appropriately)
- Write complaint with applicable modifiers—The may be different than original chief
  complaint
  o Subluxation(s) of list level(s) of area of chief complaint
  o Write condition causing patient’s complaint. This condition was considered due
to include relevant information from the patient history. It was confirmed by
  include information obtained from the exam and pertinent radiographic imaging.
  o List structural diagnosis(es) from x-rays that pertain to chief complaint i.e., DDD
    L5-S1
  o List functional diagnosis(es) i.e., Aberrant posture—lower cross
  o List soft tissue diagnosis(es) for region if applicable

Continue the list of complaints and possible related diagnoses in the order as reported by the
patient until all complaints are addressed.

Co-Morbidities: Indicate any changes in co-morbidities

Updated Management Plan: To include visits/wk, adding/subtracting PT/exercise, etc. All
items listed in the Clinical Impression must be addressed in some part of the Management/Care
Plan. Also address items from the Wellness questionnaire.
INTRODUCTION

A 50 year old male/female occupation, if retired indicate what was previous occupation and if still in productive level of education, presented to the LCWW Health Center on date 2017 for evaluation as to if chiropractic would help him/her with his/her overall wellbeing. He/She has no complaint of pain, discomfort or dysfunction. Include past chiropractic care frequency & results.

His/Her Review of Systems revealed information collected and documented including medications and supplements. Her/his Health History Questionnaire revealed include information collected and documented.

X-RAY

No x-rays were taken on this patient. If they were taken, on file for the patient continue with x-ray analysis.

FILMS DATED: ______________ E TAKEN: ______________ E TAKEN AT: ______________

VIEWS TAKEN: CERV: ______________ THOR: ______________ EXT: ______________

<table>
<thead>
<tr>
<th>Cervical Spine</th>
<th>Lumbar Spine</th>
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<td>ADI</td>
<td>millimeters</td>
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<td>Stress Lines intersected at:</td>
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<td>Gray Line falls:</td>
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<td>Lateral deviation:</td>
<td>degrees</td>
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<td>George’s Line:</td>
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<td>Listings</td>
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<tr>
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</tr>
<tr>
<td>Listing</td>
<td></td>
</tr>
<tr>
<td>Extremity</td>
<td></td>
</tr>
</tbody>
</table>

Labs/Additional Tests Performed

The patient was not referred for additional tests.

DIAGNOSIS

This section is based on the Initial Clinical Impression and examination/x-ray findings that lead to your final diagnoses.

List each diagnosis from your Initial Clinical Impression that you have ruled in. Give all the reasons you chose the particular condition including information from the history. Explain how you are ruling in the diagnosis using examination and x-ray findings.

Rev. 2/2017
## TABLE OF CONTENTS

#### SAMPLE

**Last page - Return to Section 2**

---

**INTRODUCTION**

[Text]

**TABLE 4-1**

<table>
<thead>
<tr>
<th>Cervical Spine</th>
<th>Thoracic Spine</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADI:</td>
<td>US Disc Angle</td>
</tr>
<tr>
<td>Stress Lines</td>
<td>degrees</td>
</tr>
<tr>
<td>Intersect at:</td>
<td></td>
</tr>
<tr>
<td>Grav Line falls</td>
<td></td>
</tr>
<tr>
<td>Lordosis</td>
<td></td>
</tr>
<tr>
<td>Lateral deviation:</td>
<td></td>
</tr>
<tr>
<td>George's Line:</td>
<td></td>
</tr>
<tr>
<td>Listings</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Thoracic Spine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kyphosis</td>
</tr>
<tr>
<td>Lateral deviation:</td>
</tr>
<tr>
<td>C7/C8 (if applicable)</td>
</tr>
<tr>
<td>Listings</td>
</tr>
</tbody>
</table>

*Note: Describe alignment—inclination of region. Antena/retrolisthesis, scoliosis, conference, increased/decreased kyphosis/lordosis, leg length inequality, etc.*

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*Rev. 2/2017*
### CHIROPRACTIC SCREENING EXAMINATION

**Intern:**

| Demeanor: | Alert | Orientated | Cooperative | Other |
| Appearance: | | Good | Fair | Poor |
| Distress: | None | Well nourished | Under nourished | Obese |
| Body Deformity: | None | Acquired | Congenital | Severe |
| Gait: | Unremarkable | Limp | Uses support | Unable to walk |

**Vitals:**

<table>
<thead>
<tr>
<th>Blood Pressure (seated)</th>
<th>Systolic:</th>
<th>Right:</th>
<th>Left:</th>
<th>(SPH2 if elevated)</th>
<th>Temperature:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height:</td>
<td>ft</td>
<td>in</td>
<td>Weight:</td>
<td>lbs</td>
<td>Respiration Rate:</td>
</tr>
<tr>
<td>Heart Rate:</td>
<td>min</td>
<td>Regular</td>
<td>Irregular</td>
<td>Pattern:</td>
<td></td>
</tr>
</tbody>
</table>


- **Tandem Walk:** Abnormal Describe
- **Heel Walk:** Abnormal Describe
- **Toe Walk:** Abnormal Describe
- **Rhomboid’s:** Abnormal
- **Eyes Open Describe:**
- **Eyes Closed Describe:**
- **Dorsal Echolutesia:** Abnormal
- **Upper Body Describe:**
- **Lower Body Describe:**
- **Finger to Nose:** Abnormal
- **Right:** Describe
- **Left:** Describe

**Cervical ROM**

<table>
<thead>
<tr>
<th>Direction</th>
<th>Norm</th>
<th>ROM</th>
<th>Pain, type &amp; location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexion</td>
<td>60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extension</td>
<td>60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Right Lat Flex</td>
<td>40</td>
<td></td>
<td></td>
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<tr>
<td>Left Lat Flex</td>
<td>40</td>
<td></td>
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</tr>
<tr>
<td>Right Rotation</td>
<td>00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left Rotation</td>
<td>80</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Lumbar ROM**

<table>
<thead>
<tr>
<th>Direction</th>
<th>Norm</th>
<th>ROM</th>
<th>Pain, type &amp; location</th>
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</thead>
<tbody>
<tr>
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<td>60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extension</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Right Lat Flex</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left Lat Flex</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Right Rotation</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left Rotation</td>
<td>30</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Adam’s Sign:**

- Abnormal
- Functional
- Structural

**Gilles’ Sacral:**

- +

**Notes:**

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**Posture:**

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Rev. 06/2016

---

Screening Exam continue

---

Health Center Manual: Section 4
# CHIROPRACTIC SCREENING EXAMINATION

**Interim** | **Doc #:** | **Patient:** | **File #:** | **Date:**
---|---|---|---|---

## Reflexes

<table>
<thead>
<tr>
<th>Muscle</th>
<th>Disc</th>
<th>Root</th>
<th>0 = No Response</th>
<th>3+ = brisker than average</th>
<th>1+ = Somewhat diminished</th>
<th>4+ = Hyperactive</th>
<th>2+ = Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biceps</td>
<td>L</td>
<td>C4-5</td>
<td>D 1+ 2+ 3+ 4+</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>C5</td>
<td>D 1+ 2+ 3+ 4+</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Brachioradialis</td>
<td>L</td>
<td>C5-B</td>
<td>C6</td>
<td>D 1+ 2+ 3+ 4+</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>R</td>
<td></td>
<td>D 1+ 2+ 3+ 4+</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Triceps</td>
<td>L</td>
<td>C6-7</td>
<td>C7</td>
<td>D 1+ 2+ 3+ 4+</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>R</td>
<td></td>
<td>D 1+ 2+ 3+ 4+</td>
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<td>Quadriceps</td>
<td>L</td>
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<td>1+ 2+ 3+ 4+</td>
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<tr>
<td></td>
<td>R</td>
<td></td>
<td>1+ 2+ 3+ 4+</td>
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<tr>
<td>Hamstrings</td>
<td>L</td>
<td>L4-5</td>
<td>L5</td>
<td>1+ 2+ 3+ 4+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>R</td>
<td></td>
<td>1+ 2+ 3+ 4+</td>
<td></td>
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<tr>
<td>Gastrocnemius</td>
<td>L</td>
<td>LJS</td>
<td>S1</td>
<td>1+ 2+ 3+ 4+</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>R</td>
<td></td>
<td>1+ 2+ 3+ 4+</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Babinski</td>
<td></td>
<td>C3+ R</td>
<td>FINAD</td>
<td>If positive SF43</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>C4+ L</td>
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## Subluxation Assessment

<table>
<thead>
<tr>
<th>Left</th>
<th>Level</th>
<th>Right</th>
<th>Notes</th>
<th>Listing</th>
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<tbody>
<tr>
<td>C1</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>C2</td>
<td></td>
<td></td>
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<tr>
<td>C3</td>
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<td>C4</td>
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<td>C5</td>
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<td>C6</td>
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<td>L6</td>
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<tr>
<td>L7</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>C1</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

## Muscle Strength Tests

5 = normal Complete ROM against gravity with full resistance
4 = Good Complete ROM against gravity with some resistance
3 = Fair Complete ROM against gravity with no resistance
2 = Poor Complete ROM with gravity eliminated
1 = Trace Slight contractility – no joint motion
0 = None No evidence of contractility

<table>
<thead>
<tr>
<th>Muscles</th>
<th>Root</th>
<th>Degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deltoid</td>
<td>C5</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ]</td>
</tr>
<tr>
<td>Biceps</td>
<td>C6</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ]</td>
</tr>
<tr>
<td>Triceps</td>
<td>C7</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ]</td>
</tr>
<tr>
<td>Finger Flexors</td>
<td>C8</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ]</td>
</tr>
<tr>
<td>Finger Abductors</td>
<td>T1</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ]</td>
</tr>
<tr>
<td>Infraspines</td>
<td>L12</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ]</td>
</tr>
<tr>
<td>Ankle</td>
<td>L4</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ]</td>
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<tr>
<td>Tibialis</td>
<td>L5</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ]</td>
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<tr>
<td>Extensor</td>
<td>L5</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ]</td>
</tr>
<tr>
<td>Perineal</td>
<td>S1</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ]</td>
</tr>
</tbody>
</table>

### Leg Checks:

<table>
<thead>
<tr>
<th>Supine: OL Short</th>
<th>OR Short</th>
<th>OINAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prone: OL Short</td>
<td>OR Short</td>
<td>OINAD</td>
</tr>
<tr>
<td>Derrielfield:</td>
<td>Positive</td>
<td>Negative</td>
</tr>
<tr>
<td>Cervical Syndrome:</td>
<td>Node on OL OR @ C___</td>
<td>OINAD</td>
</tr>
</tbody>
</table>

### Notes:

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**Rev. 05/2018**

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**Last page - Return to Screening Section 2**
The Administration of the College/Health Center reserves the right to add, delete, or modify the Health Center’s policies and procedures as needed.
IMAGING POLICY

The use of ionizing radiation (x-ray) in health care has been one of the great advances of modern times. In the fullness of time, we have gained a greater appreciation for advantages and disadvantages of using this technology in patient evaluations. We have also gained a greater appreciation for the consequences of unnecessary or inappropriate use of this technology.

The policies and procedures herein have been designed to give the institution, our faculty and our interns a clearer sense of when and how to employ this technology. In diagnostic Imaging there is a tension between benefit and risk as well as between cost and efficiency. We hope that these policies and procedures will help orient you to the expectations we have of our interns, faculty and consultants (radiologists) with respect to the application of x-ray imaging in the College’s Health Center.

These policies and procedures have been developed by the professional staff of the College’s Imaging Department, the College’s faculty teaching in the area of x-ray, the College’s Health Center faculty, the College’s chiropractic technique faculty and senior staff of the College’s Health Center. General policies, procedures, clinical guidelines, and best practice strategies in radiology have been considered in relation to the unique needs of the Doctor of Chiropractic. An attempt has been made to reach a reasonable, rational and supportable position in the application of x-ray utilization guidelines and practices in the chiropractic environment appreciating the unique imaging needs and perspectives of the chiropractic community.

These policies and procedures apply to all situations where patients are exposed to ionizing radiation through the College’s Health Center. Questions regarding these procedures should be directed to the Director of Imaging of the Health Center. Further, these policies and procedures are applicable to all faculty and interns functioning in the College’s Health Center. Related administrators, faculty and interns are expected to be familiar with these policies and procedures, and to refer to them in the context of any and all decisions related to imaging questions in the Health Center. As you move through the information to follow, there will be detailed information about the expectations of interns, faculty, consultants and administrators. All parties are expected to fulfill their responsibility in the decision-making, ordering, taking, reading, reporting and filing system sequence associated with the use of x-ray in the College’s Health Center. If anyone involved at any point throughout these processes has any suggestions or recommendations to facilitate the smoother and more efficient application of the policies and procedures herein, you are invited and encouraged to present your ideas to the Director of Imaging of the Health Center.

As an element of the Health Center’s Quality Assurance (QA) program, patient files are routinely reviewed. One area of this review process is related to the appropriate application of the policies and procedures detailed in this document as evidenced in patient files. Faculty members are expected to serve as a point of control relative to decisions related to the use of x-ray procedures. Consequently, the application of these policies and procedures by the Health Center faculty together with the professional judgment applied by the faculty are a key evaluation point during the QA process. As interns routinely receive feedback from Health Center faculty about patient interactions including imaging related decisions, so too do faculty receive feedback from the Health Center’s QA officer about their decisions related to these areas as well. Feedback from all parties involved in matters related to imaging in the College’s Health Center is routinely gathered, evaluated and acted upon as necessary.
In addition, new literature related to the use and interpretation of diagnostic imaging is continually coming forward. As a result, the Imaging Department reviews potential changes to these policies and procedures, and amends these materials when the need arises. When these materials are revised, there is an exchange with the Health Center Competency Testing Department, the x-ray related faculty and technique faculty to apprise every one of the changes and the timeframe for the implementation of the changes.

The decision to utilize ionizing radiation is based on the patient's case history and examination findings. An intern is expected to propose any needed imaging studies to the Health Center faculty. All relevant patient information will be integrated with the professional judgment of the faculty in the context of these policies to determine which studies are to be ordered.

Imaging studies completed at the College's Health Center must be completed following proper procedures for measurement of the patient, x-ray machine set-up, patient positioning, breathing instructions, shielding and all safety steps to insure minimal exposure to the patient, intern and Department personnel.

The entire x-ray process is the responsibility of the supervising x-ray faculty. The intern is expected to prepare for the x-ray appointment, be familiar with the studies to be conducted and be prepared to answer questions the patient or faculty member may have of them. A high level of sensitivity and professionalism is expected during the x-ray process.

A copy of the x-ray positioning protocols to be used in the Department and a copy of the California law and regulations law for radiology (Title 17) is available in the Imaging Department for intern reference.

THE FOLLOWING CASE PRESENTATION CIRCUMSTANCES HAVE BEEN DEEMED TO REQUIRE AN X-RAY EVALUATION:

A. Acute trauma with immediate loss of range of motion and pinpoint tenderness
B. Patient with history of cancer
C. Clinical suspicion of neoplasm or bone infection
D. Evidence of cauda equina
E. Inability to bear weight on extremity
F. History of spinal and/or joint surgery in region to be adjusted

X-RAYS MAY BE REQUIRED IN THE FOLLOWING CASES BASED ON THE CLINICAL JUDGMENT OF THE FACULTY INVOLVED:

A. History of trauma in region to be adjusted
B. Midline spinal pain
C. Radicular symptoms with or without spinal pain
D. Suspicion of spinal instability with spinal pain during range of motion
E. Diabetes
F. Skin conditions ex: psoriasis, eczema
G. Neurological findings
X-RAYS MAY BE REQUIRED FOR BIOMECHANICAL ASSESSMENT BASED ON THE CLINICAL JUDGMENT OF THE FACULTY INVOLVED:

A. Decreased range of motion, global
B. Decreased range of motion, segmental
C. Spinal or extremity tenderness upon palpation
D. Abnormal posture
E. Possibility of spinal anomaly, leg length inequality, suspicion of altered spinal curves

Additional x-rays may be requested by the faculty or the radiologist who has read the initial x-rays. The radiologist will notify the faculty member who will explain any required follow-up such as requesting previous x-rays, additional new x-rays, or referral recommended by the radiologist.

Student x-rays are provided, when clinically necessary, at no cost to the student.

Students are not permitted to be in the x-ray/imaging department outside of class time and imaging hours.

X-RAY APPOINTMENT SIGN UP PROCEDURE


If you have a patient who is obese please block out extra time as we may need to take additional views or take some views recumbent. If patient measures greater than 45cm at the femur heads, patient may be referred to St. Rose Hospital for Images. If you have a patient with slow or altered ambulation please block out extra time and notify x-ray faculty when you sign up for the appointment.

All patients should be instructed to arrive 15 minutes prior to the x-ray appointment, a 10 minute grace period is allowed for late patients; otherwise the patient may be rescheduled for another time and/or day.

IMAGING DEPT. PROCEDURES FOR INTERN NOT SHOWING FOR SCHEDULED X-RAY,

1. FIRST INFRACTION: WARNING

A. Imaging dept. will call/text the late intern informing them this is a warning
B. X-Ray Supervisors will alert the Director of Imaging of the Health Center, or the Customer Service Manager (in the director’s absence) of the no show. They will then enter into remarks “No show in x-ray warning given” in remarks on the Interns Chiro Clinic Page
2. Second infraction; withdraw of 5 adjustment credits.
   
   A. X-Ray Supervisors will alert Director of Imaging of the Health Center, or the Customer Service Manager (in the director’s absence) of the no show. Then they will enter “No show second infraction, 5 adjustment credits taken.” into remarks.
   
   B. Notice of concern will be filled out by Director of Imaging of the Health Center, and given to the Dean of the Health Center.

PATIENT ARRIVAL AND PRE-RADIOGRAPHIC PREPARATION PROCEDURE

A. The patient must sign in at the front desk and receive a visit slip.

B. The intern should be ready with a gown, and will escort the patient to the Imaging Department front desk. The intern will check in with the Imaging Department faculty. The intern must have the imaging request form filled out and the appropriate x-rays initialed by a Faculty Mentor, and removed from file. The intern gives the “Imaging Request” form and the “Visit Slip” to the Imaging Faculty. The faculty will direct the intern to the appropriate room.

C. If the patient is female, once in the x-ray room (for privacy, not in the waiting room, hallway, etc) the patient must sign the pregnancy waiver in the file on the Imaging Request page.

D. The intern will instruct the patient regarding proper gowning procedures. Please take the time to give clear, specific instructions. The patient may leave on underwear but should remove bra. Instruct patient to put the gown on with the opening in the back, and to ask for assistance to close the gown if needed. The patient is instructed to remove all jewelry/metal/dentures/hair-pins/bras/etc. that is in the area of the x-ray views. Rings and watches may be left on unless an upper extremity view is being taken. The patient should remove their shoes; there are paper slippers available in the dressing room if they choose. The only people allowed in the x-ray room are the faculty, work study student if available, the intern and patient. When a minor child is being x-rayed, the parent or guardian is allowed in the room. The consent to x-ray a minor form must be signed, and the parent or guardian must be present during the procedures.

E. Once the patient is gowned, the intern will perform the required measurements of the patient and record the results on scratch paper, and give to the doctor.

POST X-RAY PROCEDURE

A. After the x-rays are taken, and the x-ray faculty has approved them, the intern will instruct the patient to dress.

B. The intern will make certain they give a copy of the imaging request to the Imaging Department Faculty.

C. The intern will fill out the faculty evaluation, and have their patient fill out the imaging department evaluation, and turn in to the Director of Quality Assurance.

D. The intern will escort their patient to the cashier with the visit slip signed by the x-ray faculty.

E. The x-ray faculty will fill out the intern Imaging Assessment form, noting their progress in x-ray positioning. (See form below.)
OUTSIDE IMAGES TO BE UPLOADED TO OPAL

If an outpatient brings existing images that are less than 5 years old, the intern will fill out the imaging requisition form and attach a copy of such form to accompany the images. Give a copy to the Imaging Department Faculty who will scan and upload them into Opal. (MRI’s are not loaded into Opal, but if there is no radiology report, they can be made into a report.) After images are scanned or read, they will be returned to the Records Room.

OVERCOMING PATIENT ANXIETY REGARDING X-RAY

Keep in mind that patients often experience anxiety about having x-rays and the exposure to radiation. You must help to alleviate these concerns from the very beginning of the patient care process. Some patients have had a great deal of radiation history, and others have had little. The best way to offset this is to clearly explain what will be done, and how the x-ray examination will be conducted.

Every question the patient asks must be answered; if you are at all unsure of the correct answer the intern must have his/her mentor or x-ray faculty speak to the patient.

X-RAY RECORD REQUESTS

X-rays are the property of Life Chiropractic College West and are not to be taken from the Health Center. The Health Center will, however, provide a copy of the patient’s x-ray to a third-party following receipt of a signed authorization from the patient. There is a charge for each x-ray copy requested. When it is necessary to provide the original x-ray, it will be mailed on loan to the party indicated by the patient. All images are expected to be returned within a thirty-day period.

REQUIRED LINES OF MENSURATION:

After images have been obtained, the intern is responsible for the performance of the following biomechanical interpretations before the patient file may be submitted for a CMR.

A. Atlantodental Interspace (ADI)

Film: Lateral Cervical

This is the distance between posterior margin of the anterior arch of atlas and the anterior surface of the odontoid process as measured on the neutral lateral cervical film at 72 inches FFD. The size of the space assists in determining C1-2 stability. ADI is also considered abnormal if it increases during cervical flexion. Increased ADI may be caused by changes in the transverse ligament, such as in rheumatoid arthritis or traumatic injury.

Normal:
Adult 1-3 mm
Child 1-5 mm
B. Physiological lines of stress (Ruth Jackson’s lines)

Film: Lateral Cervical (Flexion, Extension)

Procedure: Draw a line along the posterior margin of the body of Axis. Draw a line along the posterior margin of the body of C7. Extend both lines until they meet.

Normal: The lines should intersect between C4-5 on the extension lateral and between C5-6 on the flexion lateral.

Significance: Marked alterations in the point of greatest stress and strain indicate limitations of motion due to advancing degenerative changes and discogenic spondylosis. Care must also be taken to consider the overall architecture of the spine before placing too much significance on this line. The normal cervical architecture will cause an abnormal finding which will be normal for that individual. Congenital hyperlordosis is the best example of this.

C. Gravitational line from the Odontoid Process

Film: Lateral Cervical.

Procedure: A vertical line is drawn from the apex of the odontoid inferior to the level of C7.

Normal: The line should fall within the antero-superior 1/3 of the body of C7.

Significance: Anterior to the normal range may indicate hypolordosis while Posterior to the normal range may indicate hyperlordosis of the cervical spine.

D. George’s Line

Film: Lateral Cervical.

Procedure: The line is created by drawing a continuous line on the posterior vertebral body surfaces. Care should be taken to not draw the lines connecting the superior and inferior body angles due to the frequency of hypertrophic changes in this area which must not be obscured from view by the pencil line.

Normal: The series of short lines should form a smooth, continuous anterior arc.

Significance: The line is useful in determining flexion or extension subluxations of the vertebra as these subluxations will alter the smooth flowing line to some degree, depending upon severity. Rotation will tend to give a false positive if care is not exercised in positioning this line. Anterolisthesis and retrolisthesis will also alter this line. Differentiation should be made between a “break” and an “interruption” in George’s Line. A “break” refers to a distinct anterior or posterior slippage effectively breaking the continuity of the line while an “interruption” is an alteration of the smooth continuity of the arc caused by flexion or extension subluxations.
E. Cobb’s Method for determining scoliosis

On the standard antero-posterior film, determine the end vertebra of the curvature, the highest vertebra with its superior border inclined toward the concavity and the lowest vertebra with its inferior border inclined toward the concavity. Extend these on the concave side and draw intersecting perpendiculars. The resultant angle is measured. Generally, a 5-degree increment over the Risser-Ferguson method will be obtained by this method. The Cobb’s Method is this Health Center’s preferred method. Angles greater than or equal to 20 degrees is considered scoliosis.

F. Risser-Ferguson Method for determining scoliosis

On the standard antero-posterior projection, the vertebrae situated at the extreme ends of the curvature, (the highest vertebra at the end of the curve which is the least rotated and lies between the two curves and the lowest vertebra in the curve demonstrating the same positional characteristics), are marked with a dot in the center of the bodies. In the curvature, a similar dot is placed on the apical vertebra at the peak of the curve. Lines are drawn connecting the distal dots and intersecting at the apical point. These are then joined, and their intersecting acute angle measured. When using either the Cobb or Risser-Ferguson Method, the same end vertebrae must be used when measuring comparison films.

G. Ferguson’s Gravitational Line

Film: Lateral Lumbar.

Procedure: Draw a line from the center of the body of L3 at 90 degrees to the bottom of the film.

Normal: The line should cross the anterior third of the sacral base

Significance: When the line falls >1 mm anterior to normal it may indicate an increase in anterior shearing stress on the L5-S1 facet joints. Posterior shift in the gravity line may be a sign of increased weight bearing on the lumbo-sacral facets. The line is of little significance when a transitional lumbo-sacral segment is present.

H. Ferguson’s Sacral Base Angle

Film: Lateral Lumbar.

Procedure: Draw a true horizontal line from the edge of the film. Draw a line along the sacral base intersecting with the horizontal line. Measure the acute angle formed by the intersection.

Normal: 26- 57 degrees.

Significance: An increased sacral base angle may exacerbate shearing and compressive forces on the posterior lumbo-sacral joints.

Much variation in this angle has been found by the various researchers’ studying it. One consistency arises in that almost all attribute an approximate 8-12 degree increase in the standing angle over the supine. The angle is of great significance in analyzing the lumbo-sacral motor unit’s stability and strength.
I. Lumbo-Sacral Disc Angle

Film: Lateral Lumbar.

Procedure: Draw a line along the sacral base. Draw a line along the bottom of the body of L5. Extend both lines until they intersect. The resulting angle is measured.

Normal: The angle should measure 0-15 degrees.

Significance: Angle > 15 degrees indicates facet impaction which may cause low back pain. Angle < 10 degrees may result from acute disc herniation at L5.

Please note that while Ullman’s Line is included in the sketches below, it is NO LONGER a required line of mensuration in the Health Center.

The above-outlined CMR Required Lines of Mensuration, A-I, are the minimum lines required. You should use any other measurement indicators that are effective in identifying the patient’s condition on the film.
The Administration of the College/Health Center reserves the right to add, delete, or modify the Health Center’s policies and procedures as needed.
PATIENT BILL OF RIGHTS

The Monte H. Greenawalt Health Center guarantees all patients have the right:

Receive chiropractic health care without regard to race, color, religion, sex, national origin disability, sexual orientation, or source of payment.

Full consideration of privacy concerning care. Case discussion, consultation, examinations, and care shall be treated confidentially and conducted discreetly. Patients have the right to be advised as to the reason for presence of any individual during care.

Confidential treatment of all communications and records pertaining care.

Know the identity and professional status of individuals providing care.

Receive information from the individual(s) responsible for coding care; concerning diagnosis, analysis, prognosis and the planned course of care in understandable terms.

Receive as much information about any proposed care or procedure as is needed in order to give informed consent or to refuse the course of care.

Refuse to participate in any research project. Participation in a clinical training program or the gathering of data for research purpose is always voluntary.

Description of chiropractic care, or procedures, the significant risks involved and alternate course of care.

Participate actively in decisions regarding chiropractic health care.

Expect reasonable safety insofar as health care environment is concerned.

Consultation with another health care practitioner at his or her own request and expense.

Receive an itemized detailed and through explanation of the total charges billed for services rendered, regardless of source of payment.

Access the information in their own patient file.

Present complaints, receive information on how to do so, and be provided with a response when making a significant complaint. Presentation of a complaint does not in itself to serve to compromise a patient's future access to care.

Patient Responsibilities

Each Health Center patient is an active participant in their care and must ensure that his/her actions do not infringe upon the rights of other patients or the rights and responsibilities of the Health Center. Patients shall be responsible for:

Providing to the best of his/her ability and knowledge: accurate and complete information about present complaints, past illness, incidents, Hospitalizations, and medications. It is the patient's responsibility to report any new episode of trauma or any unexpected changes in his/her health condition to the health care practitioner.

Following the recommended care plan.

Keeping appointments and notifying appropriate practitioner when unable to do so.

The consequences if she/he refuses care or does not follow up with the practitioner’s instructions.
Assuring that the financial obligations for health care are fulfilled as promptly as possible.
Following the Health Center rules and regulations affecting patient care and conduct.

Patient Care Fee Schedule

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<td>(One year or more since last visit)</td>
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<tr>
<td>X-Rays (if necessary)</td>
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Any questions or concerns should be directed to the Health Center Customer Service Manager.

Laboratory: (Lab Corp provides all service billing and collection – See Health center Front Desk for complete price listing) Draw fee required for all blood work.

Rehab and Fitness

The following patient care products are available for patient purchase in the Health Center. The item must be approved in the management plan and the visit slip signed by the faculty. The signed visit slip is taken by the intern to the Records Room where the staff member will dispense the product. The patient will pay for the item at the Cashier’s station.

The fees are available on the Online Store in Mindbody. Prices may be subject to change. [https://clients.mindbodyonline.com/ASP/home.asp?studioid=167317](https://clients.mindbodyonline.com/ASP/home.asp?studioid=167317)

X-Rays: See x-ray Fee Schedule:

### Radiology

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# TABLE OF CONTENTS

## PRODUCTS FOR SALE IN THE HEALTH CENTER

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<tr>
<td>Hip Complete -3 V</td>
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<tr>
<td>Hip Bilateral 4V</td>
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<tr>
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<tr>
<td>Knee Complete</td>
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<td>Tibia\Fibula</td>
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<td>Elbow -2V</td>
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<tr>
<td>Elbow Complete -3or 4V</td>
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<td></td>
</tr>
<tr>
<td>Radius\Ulna-2V</td>
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<tr>
<td>Wrist -2V</td>
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<tr>
<td>Wrist Complete</td>
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<tr>
<td>Hand-2V</td>
<td>$40.00</td>
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<tr>
<td>Hand Complete-3</td>
<td>$40.00</td>
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<tr>
<td>Fingers-2V Minimum</td>
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<tr>
<td>Single Film Any Area</td>
<td>$20.00</td>
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<td>Radiology Report</td>
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<td>Bone Density Scan</td>
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<tr>
<td>Balance Assessment</td>
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</tbody>
</table>

Post Films
Health Center Protocol for Addressing Patient Inquiries and Concerns

It is Health center policy to provide the highest level of patient care in an atmosphere of respect, courtesy and service. Our goal is for all patients to be completely satisfied with the services provided, and to invite an open dialog that contributes to the realization of that endeavor. We also realize that there will be times when patients may desire to discuss their care, or other matters that relate to their experiences at the Health Center. This protocol describes the sequence of response the Health Center has implemented to ensure that our patient requests, concerns, or other Issues are handled promptly, efficiently, and thoroughly.

Customer Service Inquiries or Concerns:

Issues that do not involve patient care but are related to activities of customer service, operations, the facility billing or similar topics are to be directed to the Health Center Customer Service Manager.

Patient Care Inquiries or Concerns:

Issues involving patient care, as intern's provision of services, supervising faculty functions or similar topics, are to be directed to the Compliance Officer.

Unresolved Inquiries or Concerns:

Any inquiries or concerns presented by a patient that is not promptly resolved through the above–described systems, should be immediately presented to the EVP of the Health Center for review and response. If the EVP is unavailable the time, please provide a contact information for the patient(s) and any necessary details to facilitate a timely response upon the administrator’s return or first availability.

Patient Categories –

**Cash Patient**

The patient care fee schedule*(see preceding pages) applies to cash patients. See Customer Service Assistants for complete fee schedule.

**Minor Cash Patient**

A minor is any patient who is 17 years of age or younger. The Health Center charges the following for minor patients:

Initial examination and x-rays, interim examinations, laboratory and ancillary services are provided at the standard patient care fee schedule.

Adjustments are provided at a discounted rate for minors if the parent is an active patient; otherwise, the fees are at the standard patient care fee.

**Spouse Fee Schedule:**
A discounted fee schedule only applies to patients whose spouse with an A file is currently an active patient. See the customer service manager for the fee schedule.

<table>
<thead>
<tr>
<th>Service</th>
<th>FEE</th>
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<tbody>
<tr>
<td>Initial Examination</td>
<td>$65.00</td>
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<tr>
<td>Office Visit</td>
<td>$22.00</td>
</tr>
<tr>
<td>Re-evaluation + Adjustment</td>
<td>$37.00</td>
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<tr>
<td>Reactivation</td>
<td>$65.00</td>
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<tr>
<td>Physical Therapy/Modalities</td>
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</table>

<table>
<thead>
<tr>
<th>X-RAY</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic 7</td>
<td>$120.00</td>
</tr>
<tr>
<td>Scoliosis Basic 4</td>
<td>$120.00</td>
</tr>
<tr>
<td>AP / LAT Full Spine</td>
<td>$120.00</td>
</tr>
<tr>
<td>Pre-NUCCA</td>
<td>$60.00</td>
</tr>
<tr>
<td>Post-NUCCA</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

Laboratory Fees: Lab Corp Laboratories provides all lab services, including billing and collections. See Receptionist for additional information on services and fees.

Insurance Patient

The Health Center accepts Medicare Part B insurance. The Billing Specialist will fill out the necessary forms for reimbursement. The patient is responsible for any amounts not paid Medicare including deductibles, co-payment(s), and non-covered service(s). Patients must pay for services rendered on the same day. Medicare patients will be reimbursed when payment is received from company.

Patients who have questions about insurance should be directed to the Billing Specialist.

If a patient wants, he or she may bill their own insurance company for services. The Billing Specialist will provide a visit summary statement to the patient for this purpose.

Medicare Patients

Any patient who has Medicare Part B Coverage. The patients submit a copy of their Medicare card for proper identification.

The patient is required to pay the standard fee all examinations, x-rays and ancillary services that are considered non-coverage services by the Medicare program.

Consideration for Office Visits only (adjustment) only.

The patient is required to pay the annual Medicare deductible amount or co-payment, when applicable.

The primary diagnosis, on the patient’s file and Medicare claim must indicate that of “Spinal Subluxation”. Medicare accepts NO Other diagnosis codes in consideration of reimbursement.

According to the Medicare program, “there no certain number of treatments that will be covered automatically”. The need for a service must be based upon the acute treatment modifier requirement. Effective Oct. 1st 2004 Medicare is requiring all physicians to code each visit with or without a modifier, depending on whether or not the care provided on that visit was maintenance care. Medicare has designed the modifier AT (Acute Treatment) for expected to case improvement in or arrest the progression of the patient’s condition. The AT
modifier can also be used with chronic patients when the adjustment can be expected to result in functional improvement.

Medicare patients may seek other facilities, which will accept Medicare for x-ray reimbursement. The LCCW Health Center will accept the transfer of those x-rays.

All medicare patients' chief complaints for that day will be adjusted by the practice advisor.

Ancillary Services

Any service or product provided by Health Center other than Examinations, x-rays, adjustments or physiotherapy. Example: report of findings cervical collar, ice pack, supports.

Payment Policy

Our standard fee schedule has been created to help defray the costs of health care. We have minimized our billing procedures to eliminate expense that would otherwise necessitate higher fees.

Payment is due on the day service(s) and/or product(s) are provided.

The Health Center accepts payments by cash, check (with proper identification), all major credit cards.

Health Center Fees for Students, Faculty/Staff & Faculty/Staff Family Patients

All physical examinations, adjustments, and physiotherapy are provided at no charge.

Students receive a one-time x-ray credit for a student Radiographic Package (Imaging Supplemental, page 3). This package consists of cervical, thoracic, and/or lumbar/pelvic series and base posterior view.

Students Family and student courtesy x-rays are provided at no charge as above.

Faculty/staff and family x-rays are provided at no charge.

All patients must pay for lab work at the lab facility.

Release of Patient Records

Copies of health records are only released with a valid release of records request. The cost for copies is as follow:

Copies if health records or of x-rays are provided at no cost for patients who are referred by us to another facility.

There is a $15.00 fee for health records requested by either a patient or another facility.

There is a $10.00 fee for x-rays requested by either a patient or another facility.

Records will process each request once release of records request form has been filled out and payment.

Charges for copies of records are supported by the Health and Safety Code 123110 (B) (C).