Reporting Tool

Visit Date: ___/___/_______

Association chiropratique canadienne | Canadian Chiropractic Association

Last name:	**Reason for Report:** **Initial visit** **Re-assessment** **Discharge** **Other**
First name:	
Date of Birth:	
Personal Health number:	

Diagnosis/Clinical Impression(s):

Findings:

Clinical History:

Spine (C /T /L)		
Observations		
Range of motion	**Passive**	**Active**
	________ **Flexion** ________ **Extension** ________ **R. lateral flexion** ________ **L. lateral flexion** ________ **R. rotation** ________ **L. rotation**	________ **Flexion** ________ **Extension** ________ **R. lateral flexion** ________ **L. lateral flexion** ________ **R. rotation** ________ **L. rotation**
Orthopedic tests		
Other related findings		

Neurological		
a. Sensory	**Right:**	**Left:**
b. Motor	**Right:**	**Left:**
c. Reflexes	**Right:**	**Left:**
d. Other		

Outcome Measures		
	Baseline	**Follow-up**
Pain:	**/10**	**/10**
	Baseline	**Follow-up**
Function – Activity: **Activity:** **Activity:**		
	Baseline	**Follow-up**
Disability – Test:		

Plan of Management		
	Yes (clarify)	**No**
Joint manipulation/ mobilization		
Soft-tissue therapy		
Graded exercise instruction		
Pain education, advice & reas-surance		
Other modalities		
Duration, frequency and re-evaluation		
Therapeutic goals		
Prognosis		

Recommendations and requests:

Diagnostic Imaging: ____

Testing: ____

Referral: ____

Employment status: ____

Reporting clinician:

Date completed: ____/_____/_____

Re-evaluation Date: ____/_____/_____