

Initial Examination Report - SOAP note generated on initial visit by TECHBD EMR Software

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Initial Examination Report

PATIENT: Johns Hopkins
SEX: Male
SSN: 000000123
DATE OF BIRTH: 01/23/1971
DATE OF ACCIDENT: 07/03/2007
DATE OF VISIT: 07/03/2007

SUBJECTIVE/COMPLAINTS:

COMPLAINT1: Constant left mid cervical spasm, burning. Severity level 3/10 with 10 being the most severe. This complaint is aggravated by coughing, sneezing and improved with lying down.

COMPLAINT2: Frequent left sided upper thoracic pain, burning. Severity level 1/10 with 10 being the most severe. This complaint is aggravated by twisting, lifting, sitting and improved with lying down.

HISTORY:

Mr. Johns Hopkins is a 36 yrs. old male who is being seen today for injuries sustained in a motor vehicle accident on 03/07/2007. He states that he was a front occupant in a compact car that was struck in the back end as it was accelerating. A secondary impact was also reported with a vehicle stopped in front. Visibility at the time of the accident was excellent. Road conditions were dry. The vehicle Mr. Johns Hopkins was traveling in was equipped with an airbag system at front A seat back failure was reported at the time of impact. The patient states that he was aware of the impending collision and was in a relaxed physical state with his head and neck facing forward. The estimated speed of the impact was approximately 20-30 mph. The headrest was positioned even with the head.

Mr. Johns Hopkins not admits to bodily impact within the vehicle. He reports a loss of consciousness following the impact. He went to the hospital ER by self transport immediately following the incident for evaluation and treatment of his injuries.

EMPLOYMENT HISTORY:

Current Status: Full time
Disability Details: 02/07/2007-11/07/2007
Employed By: Techbd Solutions
Employed Since: 02/07/2005

PRIOR COMPLAINTS:

CURRENT MEDICATIONS:

Albuterol, Cialis

PHYSICAL/VITALS:

Height: 5 ft. 8 in.
Weight: 142 lbs.
BP: 120 /80(L)
Pulse: 79 bpm
Temperature: 98.5 degrees
Respiration: 8 bpm

INSPECTION:

Body type: developed, left handed.
Visual inspection: Forehead Swelling, Throat Swelling, R Side of Neck Contusion, L Side of Neck Laceration,
Posture:
Gait:

REVIEW OF SYSTEMS:

General: Wnl, Fever

PALPATION:

	U-CSP	L-CSP	U-TSP	M-TSP	L-TSP	U-LSP	L-LSP	SAC	CX	PLV	EXT
Abnormal Motion	√		√			√					
Muscle Tension	2	2	5								
Muscle Spasm	√		√	√	√				√		
Trigger Points		√				√					
Edema											

RANGE OF MOTION:

Method: Dual Inclinometry
 Cervical Left Extension 60, Trace
 Cervical Right R Lat Flex 45, Poor
 Shoulder Right Flexion 180, Trace
 Shoulder Right Abduction 180, Poor

ORTHOPEDIC EVALUATION:

Georges Test: Pos Left
Jackson Compression Test: Neg Bilateral
Georges Test: Neg Left

NEUROLOGICAL EVALUATION:**Spinal Nerve Exam:**

Motor:

C7: 1/5, Abnormal Left

C8: 3/5, Abnormal Left

Reflex:

C5: 1+hypo, Abnormal Both

Sensory:

C6: Normal, Abnormal Left

ASSESSMENT/DIAGNOSIS:

The care he is receiving is reasonable, necessary and causally related to the accident in question. His current prognosis is Unspecified.

Cervical: 839.02 Subluxation of C2, 839.03 Subluxation of C3

PLAN:

TREATMENT: Chiropractic Care daily, two weeks

Man. Therapies daily, one month

Modalities daily, one month

RECOMMENDATIONS: MRI Cervical Spine

Dr. Sofiqur Rahman