St. Cloud Chiropractic Clinic & CLEAR Scoliosis Center - Patient Chart – Please Return To Front Desk

Patient Name: _____ Spouse: _____ DOB: _____

Address: _____ Tel No _____

Street City State Zip Cell No _____

Employer: _____ Occupation: _____ Email _____

Diagnosis: _____ Insurance: _____

Disability: _____ Referred By: _____

Comments: _____

History: _____

Injuries: _____

Operations: _____

Medications: _____ Drs Consulted: _____

Exam:
Posture

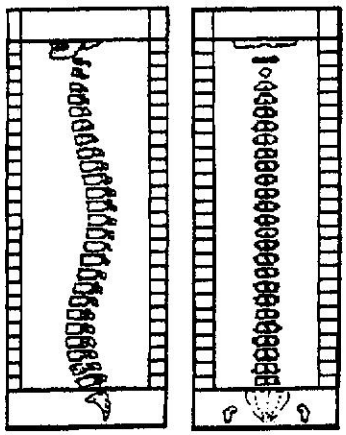
Low Back LOC _____

Stress V _____

LS < _____

L5 Retro _____

DATE DATE



Date: _____ Doctor: _____

FHP	Yes / No	Balance Test	L_____ R_____ sec
Head Tilt	Rt / Lt	Hautants	L_____ R_____ sec
Head Rot	Rt / Lt	Shd Dep	Lt / Rt
High Shd	Rt / Lt	Compression	Lt / M / Rt
High Hip	Rt / Lt	Distraction	- / +
		SLR	L_____ R_____ deg
Alar Test	Lt / Rt	Knee Raise	L_____ R_____ deg
Miller Test	+ / -	SMTT	_____
Georges Test	+ / -	BP	_____/_____ Ht_____ Wt_____
Neck ROM	F_____ E_____ LF_____ RF_____ L ROT_____ R ROT_____		
LB ROM	F_____ E_____ LF_____ RF_____ L ROT_____ R ROT_____		

Pupillary + / - Dynometer Lt _____ Rt _____

Reflexes: Bi-Lt___Rt___Tri-Lt___Rt___Dig-Lt___Rt___Pat-Lt___Rt___Ach-Lt___Rt___

Dermatomes Ulnar Lt ____ Rt ____ Medial Lt ____ Rt ____ Radial Lt ____ Rt _____

Leg Check Lt_____RT _____ TMJ: L R _____ Adjust L R L _____

Other Findings: _____

X-Ray: _____

Lat L M K S Date_____

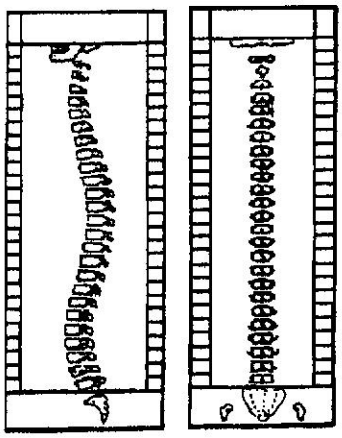
Low Back LOC _____

Stress V _____

LS < _____

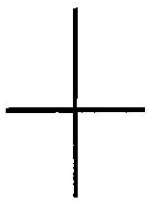
L5 Retro _____

DATE DATE

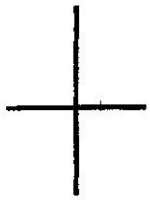


Date_____
LOC _____ %
FHP ___# _____ "
C0/ C2 _____ F / E
C1/ C2 _____ deg
C2_____
P C_____
Flexion _____ deg
Rest C_____
C0/ C2 _____ F / E
C1/ C2 _____ deg
Ext _____ deg
Rest C _____
C0/ C2 _____ F / E
C1/ C2 _____ deg
Stress X-Ray_____
Glasses __ Hd Wt ___#
LOC _____ %
FHP ___# _____ "
C0/ C2 _____ F / E
C1/ C2 _____ deg
C2 _____
P C_____

Date_____
AT____A P____
Alar_____
Sp_____



Date_____
At____A P____
Alar_____
Sp_____



DMX Date: _____
C0 _____ C1 _____ C2_____
LMSI Flex _____ LMSI Ext_____
TMJ ___Lt_____Rt_____
Alar Lt_____Rt_____#1_____
Capsular – Flex Lt _____Rt_____
Capsular – Ext Lt _____Rt_____
Rot Lt____Rt____Lat Lt____Rt_____

Scoliosis: CD _____
Thoracic _____
Lumbar _____

Scoliosis Exam	**Exam Date**	**Exam Date**
Weight: Handedness: L / R		Dominant Eye: L / R
Height:		
Lung Capacity:		
Adam's Test:		
Scoliometer; Dorsal, Prone:		
Dorsal Lumbar, Prone:		
Lumbar, Prone:		
Dorsal, Flexion:		
Dorsal Lumbar, Flexion		
Lumbar, Flexion:		
Balance Test; Left:		
Right:		
Hautant's Stork Test; Left:		
Right:		
Spinal Meningeal Tension Test:		
Shoulder Depressor:		
Foraminal Compression:		
Distraction Test		
Lasegue's Straight Leg; Left:		
Right:		
Hip Flexion Test; Left:		
Right:		
Pupillary Response:		
Cervical Flexion Test:		
Cervical Muscle Test: Flexors/Extensors		
1st Menarche		

Exercises & Rehab:

____Spinal Rotation 25x 2/day
____Exercise Cushion Lean RT / LT
Stand / Sit

____Praying Mantis
____Psoas Stretch RT / LT
____Toe Raiser RT / LT
____Cervical Dorsal Static / Dynamic
RT / LT
____SST Turn RT / LT
____Chest Expander Lean RT / LT
Stand / Sit
____Lateral Strap Lean RT / LT
Stand / Sit
____Lumbar Extension
____Axis Spinous RT___ / LT___
____Atlas Rotation RT / LT
____Cervical Ext
____Cervical Flex
____Leg Extension Basic / Advanced
RT / LT / Both
____Flex / Ext Prone
____QL Low Back RT / LT

____Leg Raise RT / LT Up
____Straight Leg Wtg RT / LT
____Leg Drag Drag RT / LT
____Spondy Ex.
____Posterior L5 Ex.

Equipment:

____Cervical Txn ____x/___/day
____Glasses
____Ant Head Wt ____#
____Head Wt RT / LT _____#
____Hip Wt _____#
RT _____ LT _____
____Air Cushion
____Diagonal Bag ____#
Hang RT / LT
____SLA Level / Down ____#
Hang RT / LT

Nutrition:

____FYI
____Omega 3
____Pure
____Vit D
____Trace Min.
____Inner Def.