

# Chiropractic Exam Form

Patient Name: \_\_\_\_\_ Case #: \_\_\_\_\_ Date: \_\_\_\_\_ Examining Doctor: \_\_\_\_\_

## SUBJECTIVES

O  
P  
Q  
R  
S  
T

## OBJECTIVES

**VITALS & VASCULAR:** Blood Pressure: \_\_\_\_/\_\_\_\_/\_\_\_\_ Pulse \_\_\_\_ bpm Respirations \_\_\_\_/Min Temperature \_\_\_\_°F Weight \_\_\_\_

**Body Type:** ENDO MESO ECTO Age \_\_\_\_ Height \_\_\_\_

**SOFT TISSUE EVALUATION:** T= tender; ATP = active trigger point; LTP = latent trigger point; J = jump sign; S = spasm; H = hypertonicity

_Mandibular depressors	_Deltoid	_Coracobrachialis	_Longissimus _____	_Vastus _____	_EDL
_Mandibular elevators	_Supraspinatus	_Pect min/maj	_Spinalis _____	_Rectus Femoris	_FL
_Suboccipitals	_Infraspinatus	_Brachialis	_Iliocostalis _____	_Adductor Magnus	_FB
_SCM	_Teres minor	_FDP/FDS	_Semispinalis _____	_Adductor Longus	_Gastro
_Deep cervical extensor	_Teres Major	_PT/PQ	_Splenius _____	_Iliopsoas	_Soleus
_Levator Scapulae	_Latissimus Dorsi	_FCR/FCU	_QL	_TFL	_Tibialis Posterior
_Trapezius	_Tricep Brachii	_ECRB/ECRL	_Gluteus _____	_Tibialis Anterior	_FHL
_Rhomboids	_Biceps brachii	_Supinator	_Piriformis	_EHL	_FDL

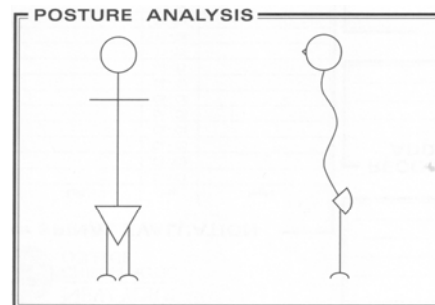
## SPINAL RANGE OF MOTION

Cervical	Norm	Active	Passive	Pain	Thoracic	Norm	Active	Passive	Pain	Lumbar	Norm	Active	Passive	Pain
Flex	80-90				Flex	20-45				Flex	80			
Extend	70				Extend	25-35				Extend	35			
LLF	20-45				LLF	20-40				LLF	25			
RLF	20-45				RLF	20-40				RLF	25			
LRot	70-90				LRot	35-50				LRot	3-18			
RRot	70-90				RRot	35-50				RRot	3-18			

## MYOTOME-DERMATOME-DEEP TENDON REFLEX

UE MUSCLE TESTING on a 5/5 scale	NEUROLOGICAL on a +5/5 scale	LE MUSCLE TESTING on a 5/5 scale	DERMATOMES
Shoulder Abduction (C5)	R L	DTR: Biceps (C5,6)	R+ L+
Wrist Extension (C6)	R L	DTR: Triceps (C7,8)	R+ L+
Wrist Flexion (C7)	R L	DTR: Brachioradialis (C6)	R+ L+
Finger Abduction (C8)	R L	DTR: Patellar (L4)	R+ L+
Heel Walk (L5)	R L	DTR: Achilles (S1)	R+ L+
Toe Walk (S1)	R L	DTR: Medial Ham (L5)	R+ L+

## ORTHOPEDIC TESTING



Clinical Impression/Assessment	Prognosis	Diagnosis Codes

**PLAN:**

Physician's Signature: \_\_\_\_\_ Date \_\_\_\_\_