

Auto Insurance Information

Name: _____ Date of Accident: _____ Date: _____

First Party Auto Insurance: (the patient's own insurance)

Insurance Company: _____

Insurance Company Phone Number: _____

Policy Number: _____

Claim Number: _____

Adjuster Name: _____

Adjuster Phone Number: _____

Third Party Auto Insurance: (other driver or other party's insurance) if applicable

Insurance Company: _____

Insurance Company Phone Number: _____

Policy Number: _____

Claim Number: _____

Adjuster Name: _____

Adjuster Phone Number: _____

At a bare minimum we require the **claim number, date of accident, and a phone number** to either the insurance company or the adjuster. Thank you for your understanding!



Whole Family Chiropractic

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PATIENT RECORDS AND DOCTOR'S LIEN

TO: ATTORNEY/ INSURANCE CARRIER

I do hereby authorize the above provider to furnish you, my attorney/ insurance carrier, with a full report of his/ her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my injury/ illness which occurred/ began on: ____/ ____/ ____.

I hereby give a lien to said provider on any settlement, judgment, or verdict as a result of said injury/ illness, and authorize and direct you, my attorney/ insurance carrier, to pay directly to said provider such sums as may be due and owing to him/ her for services rendered me, and withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect said provider adequately.

I fully understand that I am directly and fully responsible to said provider for all bills submitted by him/ her for services rendered me, and that this agreement is made solely for said provider's additional protection and in consideration of his/ her awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

I further agree to be fully responsible for reasonable attorney's fees and costs that have accrued due to the pursuance of payment of my account. Also, that in the event of noncompliance to payment agreement I understand that the amount of balance due will be subject to a 3% per month service charge.

Patients Name Printed: _____
Patient's Signature: _____ Date: ____/ ____/ ____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately the above named provider.

Attorney's Signature: _____ Date: ____/ ____/ ____

Please sign, retain a copy for your records, and return this copy to us promptly.

VITALS REGEN MED REFERRAL: Y N

Blood Pressure	O2 %	Pulse	Height	Weight	Resp (bpm)	Temp	Awake/Alert or Under Duress	Grip Dynamometry
/		bpm		lbs	bpm	°F		R: lbs (P) L: lbs (P)

HOT BUTTON/ CONDITIONS REPORTED ON INTAKE/ DURING HISTORY:

1.
2.
3.
4.
5.

LIFE EFFECT/ BUZZWORDS/ ADDITIONAL NOTES:

Life Effect #1: _____	Life Effect #2: _____	Life Effect #3: _____
Buzz-words: _____		

ROM: Performed with: VISUAL INSPECTION MYOVISION INCLINOMETER/ GONIOMETER

Cervical	N	Pt	P	Thoracic	N	Pt	P	Lumbar	N	Pt	P	Other:	Pt	P	Other:	Pt	P
Flexion	55			Flexion				Flexion	60			Flexion			Flexion		
Extension	60			Extension				Extension	25			Extension			Extension		
R Rotation	90			R Rotation				R Rotation				R Rotation			R Rotation		
L Rotation	90			L Rotation				L Rotation				L Rotation			L Rotation		
R Lat Flexion	45			R Lat Flexion				R Lat Flexion	25			R Lat Flexion			R Lat Flexion		
L Lat Flexion	45			L Lat Flexion				L Lat Flexion	25			L Lat Flexion			L Lat Flexion		

ORTHO/NEURO: MMT: (R) WNL/ NAD (L) WNL/ NAD

Test	Area	+	-	(P)/(R/L/BL)	Test	Area	+	-	(P)/(R/L/BL)	Test	R / 5	P	L / 5	P
For- Comp	Csp				SotoHall	CTLsp				Arm Abd	5-4-3-2-1-0		5-4-3-2-1-0	
For- Distr	Csp				Milgrams	Lsp				Arm Flex	5-4-3-2-1-0		5-4-3-2-1-0	
Shoulder Dep	Csp				SLR	Lsp				Arm Ext	5-4-3-2-1-0		5-4-3-2-1-0	
Apley Scratch	Shld				Thompson	Lsp				WrisFlex	5-4-3-2-1-0		5-4-3-2-1-0	
Lift Off	Shld				FAB-PAT	Lsp				Wrist Ext	5-4-3-2-1-0		5-4-3-2-1-0	
Yergason	Shld				Ant/Post-Drawer	Knee				Fngr Flex	5-4-3-2-1-0		5-4-3-2-1-0	
Speed	Shld				Bounce Home	Knee				Fngr Ext	5-4-3-2-1-0		5-4-3-2-1-0	
Codman Drop	Shld				Patellar Grind	Knee				Thm Abd	5-4-3-2-1-0		5-4-3-2-1-0	
Neers	Shld				Kernig/Brudz	Men				Hip Add	5-4-3-2-1-0		5-4-3-2-1-0	
Kennedy Hawkings	Shld				Apley Comp/Dis	Knee				Hip Abd	5-4-3-2-1-0		5-4-3-2-1-0	
ODonoghue	CTL				Lachman	Knee				Knee Flx	5-4-3-2-1-0		5-4-3-2-1-0	
George's/ Valsal	Vbi/sol				Iliac Compress	SIJ				Knee Ext	5-4-3-2-1-0		5-4-3-2-1-0	
Kemps	Lsp				Ely	Lsp				Hip Flex	5-4-3-2-1-0		5-4-3-2-1-0	
Bechterew	Lsp				Trandelenburg	SIJ				Hip Ext	5-4-3-2-1-0		5-4-3-2-1-0	
Valgus/Varus	Knee				Gillet	SIJ				DTR REFLEXES <input type="checkbox"/> WNL/ NAD				
Cozen	Elb				Ober	Hip				C5	R	0 +1 +2 +3 +4	L	0 +1 +2 +3 +4
Pinch Grip	UE				Ant Drawer	Ankle				C6	R	0 +1 +2 +3 +4	L	0 +1 +2 +3 +4
Phalen	UE				Pass Inv	Ankle				C7	R	0 +1 +2 +3 +4	L	0 +1 +2 +3 +4
Finkelstein	UE				Adam's Sign	Lsp				T1	R	0 +1 +2 +3 +4	L	0 +1 +2 +3 +4
Homans	LE				Hautant	Cere				L4	R	0 +1 +2 +3 +4	L	0 +1 +2 +3 +4
Tinels	LE				Heel-Toe	Cere				L5	R	0 +1 +2 +3 +4	L	0 +1 +2 +3 +4
Ant/Lat Compress	Tsp				Other:					S1	R	0 +1 +2 +3 +4	L	0 +1 +2 +3 +4

POSTURE: Performed with: VISUAL INSPECTION DIGITAL POSTURESREEN CRANIAL NERVES WNL/ NAD

Head	L. Translation	L. Rotation	L. Lat Flex	Ant	Flexion	EXAMINER INITIALS:	I (Olfactor)	+	V (Trig)	+	IX (Glossop)	+
Thorax	R. Translation	R. Rotation	R. Lat Flex	Post	Extension		II (Optic)	+	VI (Abd)	+	X (Vagus)	+
	L. Translation	L. Rotation	L. Lat Flex	Ant	Flexion		III (Oculo)	+	VII (Faci)	+	XI (Sp Acc)	+
Pelvis	R. Translation	R. Rotation	R. Lat Flex	Post	Extension		IV (Troch)	+	VIII (Vest)	+	XII (Hypogl)	+
	L. Translation	L. Rotation	L. Lat Flex	Ant	Flexion		Abnormality Explained:					
	R. Translation	R. Rotation	R. Lat Flex	Post	Extension							

PALPATION

Level	C0	1	2	3	4	5	6	7	T1	2	3	4	5	6	7	8	9	10	11	12	L1	2	3	4	5	SAC	LSIJ	RSIJ
Fix																												
Hypo																												
P																												

ROS:

Symptom	Explanation	Symptom	Explanation	Symptom	Explanation
HA/ Migraine		Dig Diff: IBS, HB, nausea, Constip, diarr, vomit, crmp		Falls/ Trauma, LOC	
Dizz/ Bal/ Lightheaded		Angina/ HTN		Meds/ Supp	
Fever, Chill, Night Swets		Change in B/BM Freq/Urg		Sleep Dist	
Sinus		SOB/ Asthm/ All/ Smoke		Preg. (#, Compl, C-sect)	
Tinnitus		Menstrual (cramp/bleed/irreg)		Exercise, Diet	
Vision (Blurry/ Double)		MVA		ADL's/ Hobbies/ Work	
N/T. Paresthesia		Surgery		Prev Chiro/ MD	

ORTHO/ NEURO: PEDIATRICS

Test	Region/ Area	+	-	Pain/ Notes
Head Circumference				
Chest Circumference				
McMullen Reverse Fencer pt1				
Heel Swing				
McMullen Reverse Fencer pt2				
Acetabular Pump				
Gluteal Cleft Deviation				
Leg Check Analysis				
Ortoloni				
Barlow				
Heel to Buttock				
Primitive Reflex				
Yawn, Sneeze, Hiccup, Blink				
Rooting Reflex				
Sucking Reflex				
Babinski				
Palmar Grasp				
Plantar Grasp				
Moro				
Placing				
Stepping				
Fencers				
Galant				
Perez				
Parachute				
Neck Righting				
Landau				
Femoral Torsion				
Tibial Torsion				
Pupil Constriction, Pupil Dilation				
Scapular Winging				
Ophthalmoscope				
Otoscope				
Cyanosis, Rashes				
APGAR				
Other:				
Other:				
Other:				
Other:				

ADDITIONAL NOTES:

Name: _____ Date: ___/___/___ SUBLUXATIONS: _____ POSTURE DISTORTIONS: _____ HEALTH PROBS: _____

WFC PATIENT CARE PLAN SUMMARY

PHASE I: INTENSIVE CARE

Transition your posture and body out of the immediate structural, neurological and health crisis.

I: Daily x ___ days 6 (3x2, 2x3) 12 (3x4, 2x6) 18 (3x6, 2x9) 24 (3x8) /week for _____ weeks Total Visits for INTENSIVE CARE: _____

PHASE II: CORRECTIVE CARE

Strengthen your body towards your new posture as you recover your health.

II: 12 (3x4, 2x6) 18 (3x6) 24 (3x8, 4x6) 36 (3x12, 4x9) 48 (3x16) /week for _____ weeks Total Visits for CORRECTIVE CARE: _____

PHASE III: STABILIZATION CARE

Monitor the strength and stability of your new posture while we monitor your progression to optimal health.

III: 12 (2 x per Week) 6, or 12 (1 x per Week) 24 (1 x per Week) /week for _____ weeks Total Visits for STABILIZATION CARE: _____
 12 (1 x per Month) 24 (2 x per Month) 48 (4 x per Month)

ALTERNATIVE PHASE: PREGNANCY/PRE-NATAL/INFANT CARE

Designed to improve the likelihood of a healthy pregnancy & delivery while minimizing complications and maximizing recovery.

P: 12 (3x4, 2x6, 1x12) 18 (3x6, 2x9) 24 (1 x per Week) /week for _____ weeks Total Visits for PREGNANCY CARE: _____
 12 (1x2wk-6weeks) 18 (1x2wk-9weeks) 24 (1x2wk-12weeks)

ALTERNATIVE PHASE: EXACERBATION

Designed to achieve symptom resolution and return you to your current program.

E: Daily x ___ days 6 (3x2, 2x3, 1x6) 12 (3x4, 2x6) 18 (3x6, 2x9) /week for _____ weeks Total Visits for EXACERBATION CARE: _____

PROGRAM VISITS SUMMARY: _____ (Chiro: _____, Myo: _____, Rehab: _____, Exam: _____ Other: _____) Dr. Initials: _____
***(TRELLO: Normal Complicated Auto) Work Comp/ Auto: Close & Discharge to Wellness WC/Auto Close Sheet Update Services

PROGRAM REQUIREMENTS:

- Workshop Attendance: by ___/___/___
- 99202: V1-Brief Exam
- 99203: V1-Detailed Exam
- 99204: V1-Comprehensive Exam
- 99212: Progress Re-Exam (Brief) V#: 6, 12, 15, 18, 24, 30, 36
- 99213: Detail Re-Exam (Xray) V#: 6, 12, 15, 18, 24, 30, 36
- 99214: Comprehensive Re-Exam V#: 6, 12, 15, 18, 24, 30, 36
- 95851: MyoVision C/L-DEMG/ROM: V#: _____, _____, _____
- 99354: Extra Exam/F2F Time (*Bill w/ Exam Code) (> 60min)
- 99355: Extra Exam/F2F Time (*Bill w/ Exam Code) (0-30min)
- 99358: Records Review/ Non-FacetoFace) (30-74min)
- 99359: Records Review/ Non-FacetoFace) (>74min)
- 99402: V1-Nutrition Exam/ Initial BIA w/ Consult
- 99401: Progress Nutrition Exam
- X-Ray:**
- 72040-3C V1 RX 72050-4C V1 RX 72070-2T V1 RX
- 72100-2L V1 RX 72110-4L V1 RX 72020-1S V1 RX
- 72082-FS V1 RX
- 98940: Spinal Adj: V1 Int Corr Well Prg Tot: _____
- 98941: Spinal Adj: V1 Int Corr Well Prg Tot: _____
- 98943: Extremity Ad: V1 Int Corr Well Prg Tot: _____
- 97010: ICE - PassT: V1 Int Corr Well Prg Tot: _____
- 97012: Intersegmental Traction - PassT: V1 Int Corr Well Prg Tot: _____
- 97012: C/L Disc Decompression - PassT: V1 Int Corr Well Prg Tot: _____
- 97012: CBPMirrorInrag Traction - ActT: Corr Well Prg Tot: _____
- 97014: Electric Muscle Stim - PassT: V1 Int Corr Well Prg Tot: _____
- S8990: Cold Level Laser - PassT: V1 Int Corr Well Prg Tot: _____
- 97035: Ultrasound - PassT: V1 Int Corr Well Prg Tot: _____
- 97153: Group Exercise - ActT: Corr Well Prg Tot: _____
- 97112: NMR/VibePlate Exercise - ActT: Corr Well Prg Tot: _____
- 97110: PhysTher Exercise - ActT: Corr Well Prg Tot: _____
- 97110: CBPMirrorInrag Exercise - ActT: Corr Well Prg Tot: _____
- 97140: Myo60 - ActT: Int Corr Well Prg Tot: _____
- 97124: Stretch/ Percus - ActT: Int Corr Well Prg Tot: _____
- 97535: ADL/ Home Exercise Instruction Int Corr Well Prg Tot: _____
- NC: E- V#: _____ P- V#: _____ R- V#: _____ X- V#: _____ Int Corr Well Prg Tot: _____
- NC: A T C C Int Corr Well Prg Tot: _____
- 97760: Orthotic Instruc. Initial Sole Support Scolibrace D-Roll CG Tot: _____
- L3020 (Sole Support: R) L3020 (Sole Support: L) LIFT (Misc.)
- L0180: CerviGuard E0849: Posture Pump L1005: SCOLIBRACE E0900-NU: Scoli-Ro-I T L OTHER:

*V1 = Day 1 (1st Visit)

SEE DAY 1 (V1) SERVICES RENDERED

Other/Home Care

- E0855-NU: C-Denneroll Sm Med Lg Strap
- E0900-NU: T Denneroll E0900-NU: L-Denneroll Sm Med Lg
- L0180: CerviGuard E0849: Posture Pump L1005: SCOLIBRACE E0900-NU: Scoli-Ro-I T L OTHER:

I understand my condition is progressive and could regress if I do not maintain the changes achieved with the recommendations provided. I accept responsibility to be consistent and compliant with all the above recommendations including any prescribed home care to allow the optimal opportunity for the restoration of my health.

Patient: _____ Spouse/ Guardian: _____ Date: ___/___/___

Please arrive 5 min early as the appointments may be different than what you may have become accustomed to and reflect the change in the goals for your care at the current time. Any exercises prescribed in this phase are mandatory upon instruction. Periodic re-evaluations will allow for discussion involving achievement obtained and provide an opportunity to explain any necessity for further treatment.

Any new injuries/ aggravations of your condition should be reported immediately to your doctor and a staff member ASAP.

MODIFICATIONS NECESSARY: _____

CARE PLAN DETAILS

PHASE I – INTENSIVE

Details: The Intensive Care Phase is a series of spinal and extremity adjustments accompanied by a variety of supervised passive therapies that are individualized to your exact needs. **The primary goals are relatively short-term in nature as this phase serves as the beginning of the healing process.** These include: symptom resolution, inflammation/ pain/ spasm relief, subluxation reduction and improved strength and range of motion. In doing so, the patient will experience a quicker recovery back to work, social activities, sports, and hobbies as quickly as possible.

*****Biomechanical imbalances and instabilities may persist upon conclusion of the Intensive Care Phase depending on the condition of the underlying spinal structure of the patient. Therefore, the Corrective Care Phase will be required upon conclusion of the Intensive Care Phase to prevent these injuries from returning in the future.**

Goals Include:

- | | |
|---|---|
| 1. Inflammation and Symptom Resolution | 5. Enhanced Nervous System Function and Organ Health |
| 2. Subluxation Reduction | 6. Return to Work, Sports, Hobbies |
| 3. Improved Strength, ROM, and Coordination | 7. Begin Lifestyle Modifications Based on Magnificent 7 Recommendations |
| 4. Short-Term Pain Relief and Decreased Spasm | 8. Preparation for Corrective Care Phase |

Approx. Appointment Time: **10-20min.** Adjustment times are **1-3 minutes** and the remainder of your time in the office is for therapies to help enhance the health of the nervous system and achieve the above desired goals. Please arrive 5 min early. Child supervision is available for patients in this phase. Any exercises prescribed in this phase are mandatory upon instruction.

PHASE II – CORRECTIVE

Details: The Corrective Care Phase is a series of advanced spinal and postural adjustments that are unique to this office and aimed at correcting the biomechanical instabilities and postural imbalances that are the underlying cause of the patient's condition and reduced quality of life. **The primary goals in this phase include long-term relief and maximizing organ function and spinal position.** In doing so, the patient will experience a higher quality of living and improved overall health and wellness.

Goals Include:

- | | |
|--|--|
| 1. Subluxation Correction | 4. Long-Term Pain Relief |
| 2. Postural Correction and Curve Restoration | 5. Enhanced Nervous System Function and Organ Health |
| 3. Regeneration of Intervertebral Discs/ Prevent Accelerated Aging | 6. Improve Strength, Range of Motion, Coordination |

Approx. Appointment Time: **15-20min.** Adjustment times are **1-3 minutes** and the remainder of your time in the office is spent exercising to restore spinal alignment and enhance the health of your nervous system for lifelong health and wellness. Child supervision is available for patients in this phase. Please arrive 5 min early as the appointments may be different than what you may have become accustomed to and reflect the change in the goals for your care at the current time. Any exercises prescribed in this phase are mandatory upon instruction.

PHASE III – STABILIZATION

Details: The Stabilization Care Phase is a series of spinal and postural adjustments aimed at maintaining the changes achieved in the Corrective Care Phase. This phase of care also incorporates multiple improvements in lifestyle factors that may not have been previously addressed. **The primary goal of this phase is achieving lifetime stabilization of your healthy posture and spinal structure.**

Approx. Appointment Time: **5-10min.** Approx. Adjustment Time: **1-3min** *(The remainder of your time in the office is spent exercising to maintain spinal alignment and enhance the health of your nervous system for lifelong health and wellness.)*

***EXACERBATION CARE

Details: The Exacerbation resulting from a CURRENT PLAN AGGRAVATION, or from a LAPSE IN CARE RE-INJURY can be the outcome of a regression back into a subluxated unhealthy posture or the result of a new subluxation created by a new injury. This phase is designed to be a temporary transition for you to get back onto your original care plan, or back on to your Lifetime Wellness Plan. **The primary goal of this Exacerbation Phase is to achieve symptom resolution and to return you to your current program that will produce a stronger and healthier posture and spinal structure and limit the likelihood of recurrent problems.**

*****Biomechanical imbalances and instabilities may persist upon conclusion of the Exacerbation Plan depending on the condition of the underlying spinal structure of the patient and how much progress was obtained in their current recommended plan prior to the exacerbation. Therefore, resuming the initial recommendations following resolution of the aggravated condition is recommended upon conclusion of the Exacerbation Care Phase to prevent these injuries from returning in the future.**

Goals Include:

- | | |
|---|---|
| 1. Inflammation and Symptom Resolution | 5. Enhanced Nervous System Function and Organ Health |
| 2. Subluxation Reduction | 6. Return to Initial Care Plan Recommendations |
| 3. Improved Strength, ROM, and Coordination | 7. Begin Lifestyle Modifications Based on Magnificent 7 Recommendations |
| 4. Short-Term Pain Relief and Decreased Spasm | 8. Preparation for Corrective Care Phase |

***PREGNANCY/ INFANT CARE

Details: The Pregnancy/ Infant Care Phase is a series of advanced pre-natal, post-natal and infant adjustments that are unique to this office and aimed at correcting the biomechanical instabilities and postural imbalances that are the underlying cause of the patient's condition and reduced quality of health during the various stages of pregnancy and following the birthing process with any associated traumas resulting from it. **The primary goals in this phase include minimize complications while pregnant, recovery of pre-pregnancy strength, coordination and balance after delivery and maximizing organ function and spinal position in the growing infant.** In doing so, the patient will experience a higher quality of living and improved overall health and wellness.

Goals Include:

- | | |
|--|---|
| 1. Subluxation Reduction & Enhanced Nervous System Function and Organ Health | 4. Assist with Lactation Concerns, Postural Habits, Torticollis, Milestones |
| 2. Assist with Intrauterine Constraint/ Abnormal Positioning | 5. Review Appropriate Nutritional Support During and After Pregnancy & Delivery |
| 3. Recovery from Birth Trauma (difficult labor, shoulder dystocia, hip dysplasia, etc) | 6. Improve Strength, Range of Motion, Coordination, and Pain During Pregnancy |

OFFICE VISIT	NEW	EST	CHARGE	XRAYS	CODE	CHARGE
<input type="checkbox"/> Consult & Screen - C	CPE1	CPE2	130/80	<input type="checkbox"/> Full Spine: AP/LAT	72082	305
<input type="checkbox"/> Brief Focused Exam	CPE1	99211	80/105	<input type="checkbox"/> Full Spine: AP/LAT C		230
<input type="checkbox"/> Problem Focused Exam	99201	99212	230/205	<input type="checkbox"/> Spine: Single View/ 1 Region	72020	170
<input type="checkbox"/> Expanded Exam	99202	99213	330/305	<input type="checkbox"/> Spine Single View/ 1 Region - CPX		80
<input type="checkbox"/> Detailed Exam	99203	99214	430/405	<input type="checkbox"/> Cervical: 3-View or Less	72040	280
<input type="checkbox"/> Comprehensive Exam	99204		530	<input type="checkbox"/> Cervical: 4-5 View	72050	300
<input type="checkbox"/> Additional Exam - Procedures/ Time/ Scan	99354	99355	155	<input type="checkbox"/> Cervical: 6 View	72052	310
<input type="checkbox"/> Notes Review	99358	99359	130	<input type="checkbox"/> Thoracic: 2 View	72070	220
<input type="checkbox"/> Activities of Daily Living (ADLs)		97535-I/C	95 / 25	<input type="checkbox"/> Thoracolumbar: 2 View	72080	230
<input type="checkbox"/> Computer Range of Motion/ Neck or LB (MyoVision)		95851C/L	115	<input type="checkbox"/> Ribs: 2 Unilat	71110	120
<input type="checkbox"/> Nutritional and/or Detox Consult - BIA	99402		130	<input type="checkbox"/> Lumbosacral: 2 View	72100	215
<input type="checkbox"/> Nutritional and/or Detox Consult - BIA		99401	80	<input type="checkbox"/> Lumbosacral: 4 View	72110	305
CHIROPRACTIC SPINAL ADJUSTMENT	CODE	CHARGE		<input type="checkbox"/> Lumbosacral Comp/Bending	72114	330
<input type="checkbox"/> Adjustment 1-2 Regions		98940	75	<input type="checkbox"/> Shoulder: 1 View	73020	155
<input type="checkbox"/> Adjustment 1-2 C			42	<input type="checkbox"/> Shoulder: 2 View	73030	230
<input type="checkbox"/> Adjustment 3-4 Regions		98941	90	<input type="checkbox"/> Elbow: 2 View	73070	125
<input type="checkbox"/> Adjustment 3-4 C			55	<input type="checkbox"/> Wrist: 2 View	73100	120
<input type="checkbox"/> Adjustment 5 Regions		98942	105	<input type="checkbox"/> Hand: 2 View	73120	160
<input type="checkbox"/> Adjustment 5 Regions C			72	<input type="checkbox"/> Hip: 1 View	73501	170
<input type="checkbox"/> Out of Office Adj			105	<input type="checkbox"/> Hip: Unilateral Comp 2 View	73502	230
<input type="checkbox"/> Adjustment Extraspinal		98943	65 (C:25)	<input type="checkbox"/> Hip: 2 View Bilateral	73521	270
MODALITIES	CODE	CHARGE	UNITS	<input type="checkbox"/> Knee: 2 View	73560	180
<input type="checkbox"/> CBP Mirror Image Traction		97012	65 x _____ units	<input type="checkbox"/> Knee: 4 View	73564	220
<input type="checkbox"/> CBP Mirror Image Traction C			25 x _____ units	<input type="checkbox"/> Ankle: 2 View	73600	130
<input type="checkbox"/> Traction Mechanical (Intersegmental Table)		97012	65 x _____ units	<input type="checkbox"/> Foot: 2 View	73620	125
<input type="checkbox"/> Traction Mechanical (Intersegmental Table) C			25 x _____ units	<input type="checkbox"/> Leg Length Study:	77073	80
<input type="checkbox"/> Decompression Traction		97012	65 x _____ units	DME (SCOBRAC/ORTH/DROLL) FITTING	CODE	CHARGE
<input type="checkbox"/> Decompression C			25 x _____ units	<input type="checkbox"/> Initial Orthotic(s) Train/ Fit	97760	130
<input type="checkbox"/> EMS/ Stim Unattended		97014	60 x _____ units	<input type="checkbox"/> Est. Orthotic(s) Train/ Fit	97763	105
<input type="checkbox"/> EMS/ Stim Unattended C			25 x _____ units	DME/ HOME CARE	CODE	CHARGE
<input type="checkbox"/> Ultrasound		97035	55 x _____ units	<input type="checkbox"/> Scolibrace	L1005	4500
<input type="checkbox"/> Ultrasound C			25 x _____ units	<input type="checkbox"/> Denneroll Cervical (Ped/ Sm/ M/ L)	E0855-NU	130 (C: 55)
<input type="checkbox"/> Cold Laser			25 x _____ units	<input type="checkbox"/> Denneroll Cervical Strap		30
<input type="checkbox"/> Ice/ Heat		97010	25 x _____ units	<input type="checkbox"/> Denneroll Thoracic <input type="checkbox"/> Tsp Comp-Ext Block	E0900-NU	150 (C:50)
THERAPEUTIC EXERCISE	CODE	CHARGE	UNITS	<input type="checkbox"/> D-Roll Posture Regainer <input type="checkbox"/> D-Roll 2Way Set	E0900-NU	130 (C:80)
<input type="checkbox"/> CBP Mirror Image Exercise/ Power Plate 15 Min		97110	75 x _____ units	<input type="checkbox"/> Denneroll Lumbar (Sm/ M/ L)	E0900-NU	150 (C:80)
<input type="checkbox"/> CBP Mirror Image Exercise/ Power Plate 15 Min C			25 x _____ units	<input type="checkbox"/> Scoli-Roll (T / L)	E0900-NU	150 (C:80)
<input type="checkbox"/> Therapeutic Exercise/ Procedure 15 Min		97110	75 x _____ units	<input type="checkbox"/> Posture Pump	E0849	700 (C:350)
<input type="checkbox"/> Therapeutic Exercise/ Procedure 15 Min C			25 x _____ units	<input type="checkbox"/> Pro-Lordotic Exerciser (R, B, G)		65
<input type="checkbox"/> Group Exercise		97530	55 x _____ units	<input type="checkbox"/> Stroops Trainer (L, M, H)		55
<input type="checkbox"/> Group Exercise C			25 x _____ units	<input type="checkbox"/> Stroops Deluxe Loop		55
<input type="checkbox"/> Neuromuscular Re-Education		97112	75 x _____ units	<input type="checkbox"/> Cervi-Guard FHP Device	L0180	400 (C:275)
<input type="checkbox"/> Neuromuscular Re-Education C			25 x _____ units	<input type="checkbox"/> Foam Roll - 6"		50
<input type="checkbox"/> Massage 15 Min		97124	77 x _____ units	<input type="checkbox"/> Denneroll Pillow: 155 <input type="checkbox"/> D-Roll Pillow Insert:		45
<input type="checkbox"/> Massage 15 Min C			25 x _____ units	<input type="checkbox"/> Lumbar Brace: (S, M, L, X, 2X, 3X)	99070	80 (C:45)
<input type="checkbox"/> Manual Therapy/ Myofascial 15 Min		97140	77 x _____ units	<input type="checkbox"/> Back Hugger		45
<input type="checkbox"/> Manual Therapy/ Myofascial 15 Min C			25 x _____ units	<input type="checkbox"/> Foot Insert - Sole Support	L3020	410
<input type="checkbox"/> Taping/ Percussion/ Stretching		97124	77 x _____ units	<input type="checkbox"/> Foot Lift - Sole Support 6mm		30
<input type="checkbox"/> Taping/ Percussion/ Stretching C			25 x _____ units	<input type="checkbox"/> Wobble Disc		30
***OFFICE USE ONLY - NC	CODE			<input type="checkbox"/> Posture Exercise Block 6"		40
<input type="checkbox"/> Consult/ Exam/ Progress Exam/ Re-Exam		NC-C, NC-E, NC-P, NC-R		<input type="checkbox"/> SpiderTech Tape (Precut/ X-10pk/ X,I,V -ind)	P:20 X10:10 XIV:5	
<input type="checkbox"/> Xray		NC-X		<input type="checkbox"/> Wrist/ Ankle/ Knee Brace: (S, M, L, X, 2X)	W:24 A:42 K:65	
<input type="checkbox"/> Adj		NC-A		<input type="checkbox"/> Maternity Brace: (S, M, L, X, 2X, 3X)		55
<input type="checkbox"/> Active Therapy: PT Exercise/ Corrective Care		NC-PT, NC-CC		<input type="checkbox"/> Bellies Wrap/Sys: (S, M, L, X, 2X, 3X)	BS:155/ BW: 85	
<input type="checkbox"/> Passive Therapy: EMS/ IST/ Laser/ US		NC-T		<input type="checkbox"/> SI Brace: (S, M, L, X, 2X, 3X)		30

MEDICARE

MAJOR MEDICAL/ CASH

PIP/ WC

DIAGNOSIS:

1-4 5-8 9-12

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Subluxation	C, T, L, S,P, Extremity: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tension HA (Uncontrolled)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tension HA (Controlled)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine (uncontrolled)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine (Controlled)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L Fusion	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L/S Fusion	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C Disc Displacement (C2/3-3/4)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C Disc Displacement (C4-5)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C Disc Displacement (C5-6)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C Disc Displacement (C6-7)	

1-4 5-8 9-12

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C/T Disc (C7-T1)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C Radiculopathy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C/T Radiculopathy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C DJD C2/3-3/4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C DJD C4-5)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C DJD C5-6)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C DJD C6-7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	T Radiculopathy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	T/L Radiculopathy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica R
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica L
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L Disc
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L/S Disc
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L Spinal Instability
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L/S Spinal Instability

1-4 5-8 9-12

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L DJD
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L/S DJD
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wellness Dx
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Common Csp RMVC
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Common Lsp RMVC
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ASSOCIATED/ COMPLICATING DX
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MyoTherapy 97124 Pointer Dx Codes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M25.511 - RT Shoulder P
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M25.512 - LT Shoulder P
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M25.551 - RT Hip P
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M25.552 - LT Hip P

Whole Family Chiropractic Home Care Package

Patient Name: _____

Date: __/__/__

Your Home Care Package contains the following items to be performed as prescribed by your provider:

Spinal Remodeling Orthotic:

Designed to assist the corrective chiropractic care and traction in the office by providing the ability to perform gentle spinal remodeling at home without supervision

<u>Type:</u>	<u>Size:</u>	<u>Placement:</u>	<u>Time:</u>
<input type="checkbox"/> Cervical Denneroll	<input type="checkbox"/> Small/ Pediatric	<input type="checkbox"/> Upper Cervical	<input type="checkbox"/> AM
<input type="checkbox"/> Thoracic Denneroll	<input type="checkbox"/> Medium	<input type="checkbox"/> Mid Cervical	<input type="checkbox"/> PM
<input type="checkbox"/> Lumbar Denneroll	<input type="checkbox"/> Large	<input type="checkbox"/> Lower Cervical	
<input type="checkbox"/> 2 Way Extension Denneroll			<input type="checkbox"/> 5min
<input type="checkbox"/> Posture Regainer Denneroll		<input type="checkbox"/> Upper Thoracic	<input type="checkbox"/> 10min
<input type="checkbox"/> Scoli-Roll Thoracic		<input type="checkbox"/> Lower Thoracic	<input type="checkbox"/> 15min
<input type="checkbox"/> Scoli-Roll Lumbar			
<input type="checkbox"/> w/ Thoracic Block		<input type="checkbox"/> Upper Lumbar	<input type="checkbox"/> Daily
<input type="checkbox"/> w/ Denneroll Strap			<input type="checkbox"/> 3x/wk
			<input type="checkbox"/> 5x/wk
<input type="checkbox"/> Posture Pump			
<input type="checkbox"/> Cervi-Guard			

Sole Supports Pelvic Orthotics / Pelvic Stabilizers and Arch Supports:

Designed to stabilize abnormal gait and postural biomechanical deviations associated with an anatomical leg length inequality

- Frequency:**
- Daily
 - 2-4 Hours
 - 4-6 Hours
 - 6-8 Hours
 - Whenever Upright/ All Day

Full Foot Lift:

Designed to help correct abnormal pelvic posture associated with an anatomical leg length inequality

- Side that you are to wear it on: **RIGHT** **LEFT**
- Millimeters of lift recommended: **1** **2** **3** **4** **5** **6**

- Frequency:**
- Daily
 - 2-4 Hours
 - 4-6 Hours
 - 6-8 Hours
 - Whenever Upright/ All Day

Pregnancy Support Band:

Designed to support growing weight of baby and alleviate pressure from spinal and pelvic joints

<u>Type:</u>	<u>Size:</u>	<u>Frequency:</u>
<input type="checkbox"/> Belly Band	<input type="checkbox"/> Small	<input type="checkbox"/> Daily
<input type="checkbox"/> Shoulder Strap	<input type="checkbox"/> Medium	<input type="checkbox"/> 2-4 Hours
<input type="checkbox"/> Groin Band	<input type="checkbox"/> Large	<input type="checkbox"/> 4-6 Hours
<input type="checkbox"/> Ab Wrap	<input type="checkbox"/> X-Large	<input type="checkbox"/> Whenever Upright/ All Day
<input type="checkbox"/> Ab System	<input type="checkbox"/> 2X-Large	
<input type="checkbox"/> Maternity Support Brace		

Whole Family Chiropractic/ Whole Family Integrated Wellness Home Care Package

*** PRE-AUTH: [] REQUIRED [] COMPLETE
*** L.M.N. : [] REQUIRED [] COMPLETE

Patient Name: _____ Date: ___/___/___

DME DEMO CODE: 97760

Your Home Care Recommendation(s) contain the following items to be performed as prescribed by your provider:

SPINAL REMODELING ORTHOTIC:

Designed to assist the corrective chiropractic care and traction in the office by providing the ability to perform gentle spinal remodeling at home without supervision

Type:	INS CODE:	Size:	Placement:	Time:
<input type="checkbox"/> Cervical Denneroll	E0855-NU	<input type="checkbox"/> Small/ Pediatric	<input type="checkbox"/> Upper Cervical	<input type="checkbox"/> AM
<input type="checkbox"/> Thoracic Denneroll		<input type="checkbox"/> Medium	<input type="checkbox"/> Mid Cervical	<input type="checkbox"/> PM
<input type="checkbox"/> Lumbar Denneroll	E0900-NU	<input type="checkbox"/> Large	<input type="checkbox"/> Lower Cervical	
<input type="checkbox"/> 2 Way Extension Denneroll				<input type="checkbox"/> 5min
<input type="checkbox"/> Posture Regainer Denneroll		<input type="checkbox"/> Upper Thoracic		<input type="checkbox"/> 10min
<input type="checkbox"/> Scolio-Roll Thoracic	E0900-NU	<input type="checkbox"/> Lower Thoracic		<input type="checkbox"/> 15min
<input type="checkbox"/> Scolio-Roll Lumbar	E0900-NU			
<input type="checkbox"/> w/ Thoracic Block		<input type="checkbox"/> Upper Lumbar		<input type="checkbox"/> Daily
<input type="checkbox"/> w/ Denneroll Strap				<input type="checkbox"/> 3x/wk
				<input type="checkbox"/> 5x/wk
<input type="checkbox"/> Posture Pump	E0849			
<input type="checkbox"/> Cervi-Guard	L0180			

SOLE SUPPORTS ORTHOTICS/ PELVIC STABILIZER & ARCH SUPPORT:

RIGHT SIDE: L3020

LEFT SIDE L3020

Designed to stabilize abnormal gait and postural biomechanical deviations associated with an anatomical leg length inequality

Frequency: Daily 2-4 Hours 4-6 Hours 6-8 Hours Whenever Upright/ All Day

FULL FOOT LIFT:

Designed to help correct abnormal pelvic posture associated with an anatomical leg length inequality

Side that you are to wear it on: **RIGHT** **LEFT**

Millimeters of lift recommended: **1 2 3 4 5 6**

Frequency: Daily 2-4 Hours 4-6 Hours 6-8 Hours Whenever Upright/ All Day

PREGNANCY SUPPORPT BANDS:

INS CODE: _____

Designed to support growing weight of baby and alleviate pressure from spinal and pelvic joints

Type:	Size:	Frequency:
<input type="checkbox"/> Belly Band	<input type="checkbox"/> Small	<input type="checkbox"/> Daily
<input type="checkbox"/> Shoulder Strap	<input type="checkbox"/> Medium	<input type="checkbox"/> 2-4 Hours
<input type="checkbox"/> Groin Band	<input type="checkbox"/> Large	<input type="checkbox"/> 4-6 Hours
<input type="checkbox"/> Ab Wrap	<input type="checkbox"/> X-Large	<input type="checkbox"/> Whenever Upright/ All Day
<input type="checkbox"/> Ab System	<input type="checkbox"/> 2X-Large	
<input type="checkbox"/> Maternity Support Brace		

TENS UNIT:

INS CODE: _____

Recommended to assist in inflammation and pain reduction and decreasing dependency on medication

Side that you are to wear it on: **RIGHT** **LEFT**

Location: Neck Shoulder Mid Back Low Back Hip Thigh Other: _____

Frequency: Daily or Weekly _____ x/ Day or _____ x/ Week for: **5 10 15 20 30** minutes

BRACES:

Recommended to assist in stabilizing and protecting injured area to prevent further aggravation and aid healing

Type:	SPINAL	UPPER EXTREMITY	LOWER EXTREMITY
<input type="checkbox"/> TLSO	INS CODE: _____	<input type="checkbox"/> Shoulder	INS CODE: L3678
<input type="checkbox"/> LSO	INS CODE: _____	<input type="checkbox"/> Shoulder – ICE	INS CODE: L3678
<input type="checkbox"/> Standard Low Back	INS CODE: L0625	<input type="checkbox"/> Elbow	INS CODE: L3761
<input type="checkbox"/> Low Back - ICE	INS CODE: L0625	<input type="checkbox"/> Elbow – ICE	INS CODE: L3761
<input type="checkbox"/> Back Hugger	INS CODE: E0190	<input type="checkbox"/> Wrist	INS CODE: L3908
<input type="checkbox"/> Denneroll Pillow	INS CODE: E0190	<input type="checkbox"/> Wrist - ICE	INS CODE: L3908
		<input type="checkbox"/> SIJ Belt	INS CODE: L0621
		<input type="checkbox"/> Knee – UNLOADER	INS CODE: _____
		<input type="checkbox"/> Knee – PATELLA	INS CODE: _____
		<input type="checkbox"/> Knee - STANDARD	INS CODE: _____
		<input type="checkbox"/> Ankle	INS CODE: L1951
		<input type="checkbox"/> Ankle – ICE	INS CODE: L1951

Frequency: Daily or Weekly _____ x/ Day or _____ x/ Week for: _____ minutes _____ hours

Whole Family Chiropractic

600 E 36th Ave, Suite 300 – Anchorage, AK 99503 – P:907.562.3060 – F:907.562.3061 - wholefamilychiropractic.com

Myotherapy Referral Recommendation Form (CPT: 97140)

Patient Name: _____ Date: ___/___/___ Diagnosis: 1° ___ 2° ___ 3° ___ 4° ___

Based upon findings during the examination/ re-evaluation on: ___/___/___, and the subsequent clinical diagnosis(es) above, this patient qualifies for myotherapy treatments specifically targeting the following regions and the associated muscle groups below;

HEAD & FACE	L	R	UPPER EXTREMITY	L	R
Occipitalis	___	___	Coracobrachialis	___	___
Temporalis	___	___	Biceps Brachii	___	___
Auricularis	___	___	Triceps Brachii	___	___
Frontalis	___	___	Pronator Teres	___	___
Procerus	___	___	Flexor Carpi Ulnaris	___	___
Levator Labii	___	___	Palmaris Longus	___	___
Semispinalis /Splenius Cap	___	___	Flexor Carpi Radialis	___	___
Rectus Capitis Post	___	___	Flexor Pollicis Longus	___	___
Obliquus Capitis	___	___	Supinator	___	___
Masseter	___	___	Brachioradialis	___	___
Buccinator	___	___	Anconeus	___	___
Zygomaticus Major/ Minor	___	___	Extensor Carpi Radialis	___	___
Risorius	___	___	Extensor Digitorum/ Digiti Minimi	___	___
Pterygoid Med/ Lat	___	___	Extensor Carpi Ulnaris	___	___
			Extensor Pollicis	___	___
			Flexor Pollicis	___	___
			Abductor Pollicis	___	___
			Adductor Pollicis	___	___
			*Palmar Aponeurosis	___	___
			Flexor/ Adductor Digiti Minimi	___	___
			Palmar/ Dorsal Interossei	___	___
NECK	L	R	LOWEE EXTREMITY	L	R
Upper Trapezius	___	___	Rectus Femoris	___	___
Ant/ Post/ Middle Scalene	___	___	Vastus Med/ Lat	___	___
Sternocleidomastoid	___	___	Gracilis	___	___
Semispinalis	___	___	Sartorius	___	___
Platysma	___	___	Adductor	___	___
Infra/ Suprahyoid	___	___	Tensor Fascia Latae	___	___
Splenius Cervicis	___	___	Gluteus Med/ Max	___	___
Interspinalis Cervicis	___	___	* IT Band	___	___
Levator Scapula	___	___	Piriformis	___	___
			Semitendinosus/ Membranosus	___	___
			Biceps Femoris	___	___
			Popliteus	___	___
			Tibialis Anterior	___	___
			Fibularis	___	___
			Extensor Digitorum/ Hallucis	___	___
			Gastrocnemius	___	___
			Soleus	___	___
			* Achilles	___	___
			Tibialis Posterior	___	___
			Flexor Digitorum/ Hallucis	___	___
			Plantar Aponeurosis	___	___
			Dorsal/ Plantar Aponeurosis	___	___
			Abductor Hallucis/ Digiti	___	___
THORAX	L	R			
Ant/ Lat/ Post Deltoid	___	___			
Supraspinatus	___	___			
Infraspinatus	___	___			
Teres Minor/ Major	___	___			
Subscapularis	___	___			
Latissimus Dorsi	___	___			
Rhomboid Major/ Minor	___	___			
Ant/ Post Serratus	___	___			
Int/ Ext Intercostals	___	___			
Semispinalis Thoracis	___	___			
Multifidi (Levels: _____)	___	___			
Erector Spinae (Levels: _____)	___	___			
Interspinalis Lumborum	___	___			
Psoas Major/ Minor	___	___			
Iliacus	___	___			
Iliopsoas	___	___			
Quadratus Lumborum	___	___			
ANTERIOR ABDOMINAL WALL	L	R			
Int/ Ext Oblique	___	___			
Rectus Abdominis	___	___			
*Inguinal Lig.	___	___			

Myotherapy has been recommended in the above marked areas for _____ wks, at a frequency of _____ x/wk (or every _____ wks). A clinical re-evaluation is scheduled for ___/___/___ to determine further medical necessity.

Case History and Examination Findings: ___ Attached ___ Have Been Forwarded Under Separate Cover ___ Will Be Forwarded Upon Request
 Recommendations in conjunction with Myo (describe details below): ___ Ice ___ Heat ___ Stretch ___ Exercise ___ Supplements

Exercises Reviewed by: _____ Doctor _____ Myotherapist

Clinical Goals/ Notes/ Remarks: _____

Whole Family Chiropractic

600 E 36th Ave, Suite 300 – Anchorage, AK 99503 – P:907.562.3060 – F:907.562.3061 - wholefamilychiropractic.com

Nutritional Supplement Recommendations

Patient Name: _____ Date: _____ Age: _____ Ht/Wt: _____ / _____
 Allergies: _____
 Chief Complaint: _____

Acute	Days			Weeks		Re-Evaluation in 30 45 60 90 Days			
	# of Bottles	Product	Upon Arising	With Breakfast	Mid Morning	With Lunch	Mid Afternoon	With Dinner	Before Sleep

Clinical Goal: _____

Subacute	Days			Weeks		Re-Evaluation in 30 45 60 90 Days			
	# of Bottles	Product	Upon Arising	With Breakfast	Mid Morning	With Lunch	Mid Afternoon	With Dinner	Before Sleep

Clinical Goal: _____

Chronic or Wellness	Days			Weeks		Re-Evaluation in 30 45 60 90 Days			
	# of Bottles	Product	Upon Arising	With Breakfast	Mid Morning	With Lunch	Mid Afternoon	With Dinner	Before Sleep

Clinical Goal: _____

Recommended Supportive Care UltraInflamX Program Modified Elimination Diet Detoxification Program

Home Care Recommendations

Ice _____ x/ day for _____ min Alternate Ice/ Heat _____ x/ day for _____ min
 Heat _____ x/ day for _____ min Topical (Biofreeze) _____ x/ day for _____ min
 Stretching _____ x/ day Areas: _____ Sets: _____ Reps: _____

Restrictions on Activity include: _____

BIA Evaluation Date: _____ **Re-Evaluation in 10 30 45 60 90 Days**

Lab Analysis Date: _____ **Re-Evaluation in 10 30 45 60 90 Days**

Doctor Signature: _____ **Date:** _____

*** The nutraceuticals listed above have been chosen for their quality, potency, and specificity to your needs. Do not substitute a similar product or another brand except on the recommendations of your healthcare practitioner. If you have questions as to why the products are recommended please do not hesitate to inquire.

***All purchases of supplements and nutraceuticals are final. No returns or exchanges are permitted.

FUNCTIONAL MEDICINE / SUPPLEMENTS

MULTIVITAMINS/ PACKS

PhytoMulti:	65.00	x	Phytomultiw/o Iron:	38.00	x		
Multi Chew:	22.00	x	Catalyn Chew:	15.00	x	Catalyn GF :	40.00 x
WellEssential M:	64.00	x	WellEssential F:	57.00	x	Plus 1:	49.00 x

FISH OIL

EPA 1,000:	86.00	x	EPA Liquid:	44.00	x	EPA Neuro:	42.00 x
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Vit D3

D3 5:	22.00	x	D3 10:	26.00	x	D3Liq:	22.00 x
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PROBIOTICS

UltraFlora Bal:	68.00	x	Ultraflora Syn:	40.00	x	UltraFlora Resp:	49.00 x
Ultraflora Wom:	24.00	x	Ultraflora Cont:	40.00	x	UltraFlora Boost:	32.00 x

KIDS

MetaKidsPowder:	37.00	x	MetaKids DHA:	20.00	x	Metakids DHAD3:	19.00 x
MetakidsChew:	44.00	x	MetakidsKPro:	55.00	x	Metakids Baby:	28.00 x

ORGANO GOLD (OG) GANODERMA/ MUSHROOMS

OG Spores:	98.00	x	OG Luciderm:	63.00	x	OG Mycellium:	63.00 x	OG Fenix:	68.00 x
OG-Blk Coff :	27.00	x	OG-Mocha :	31.00	x	OG Latte :	27.00 x	OG King :	47.00 x
OG-GRN T :	34.00	x	OG-RED T:	34.00	x	OG Choc:	31.00 x		

IMMUNITY

VitC Chew:	22.00	x	VitC 1,000 :	30.00	x	IMM-Core:	35.00 x
Nazanol:	21.00	x	Pneumocarotene:	20.00	x	Echinacea:	23.00 x
Essential Defense:	15.00	x	Perimine	27.00	x		

ANTI-INFLAMMATORY/ ANTI OXIDANT

Kaprex:	53.00	x	Chondrocare:	45.00	x	SPM:	69.00 x
Mata Lipoate:	36.00	x	Celapro:	30.00	x	Greens / Berry First:	45.00 x
Candibactin BR:	37.00	x	Protrypsin:	24.00	x	Mag Glycinate:	43.00 x

DIGESTION

Spectrazyme:	55.00	x	Spectrazyme Glut:	55.00	x	Glutagenics:	18.00 x
UltraInflamx:	71.00	x					

DETOX

Metalloclear:	49.00	x	Advaclear:	80.00	x	Glutaclear:	41.00 x
Meta 13C	76.00	x	UC Renew:	84.00	x	AxisEndo:	53.00 x

KETOGENIC

Exogenous Ketones:	59.00	x	MCT Oil:	49.00	x	Chromium Picolinate:	11.00 x
Keto Shake:	56.00	x					

WEIGHT LOSS/ SPORTS/ LIFESTYLE

M-Fit:	50.00	x	BCAA:	33.00	x	Endura :	27.00 x
UC Gluc:	69.00	x	ML-Perfect Protein :	65.00	x		

CARDIOVASCULAR

Hemagenics:	42.00	x	Vasotensin:	48.00	x	CoQ10:	51.00 x
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SLEEP

Bensom:	52.00	x	MyoCalm:	11.00	x		
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STRESS/ FOCUS/ CONCENTRATION/ MOOD

Adresct:	34.00	x	Adrenogen:	55.00	x	Trancor:	48.00 x
Serosyn:	71.00	x	BioSom:	19.00	x		

NERVOUS SYSTEM/ BRAIN:

Neurosol:	42.00	x	Ceralin Forte:	55.00	x		
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WOMENS HEALTH

FemEssentials:	20.00	x	HerSynergy:	45.00	x	FemPremenstrual:	19.00 x	Village Herbs:	20.00 x
Estrovera:	94.00	x	Osteovantiv:	54.00	x	Thyrosol:	39.00 x		

MENS HEALTH

HisSynergy:	23.00	x	Zinc:	12.00	x	UltraProstate:	44.00 x	Testralin:	55.00 x
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NORDIC NATURALS

NN-Berries:	34.00	x	NN-OM Focus:	39.00	x	NN-Child DHA:	21.00 x	NN-DHA JR:	17.00 x
NN-Pixies:	27.00	x	NN-Curcumin:	29.00	x	NN-Melatonin:	19.00 x	NN-Collagen:	29.00 x