CHIROPRACTIC
WELLNESS CENTER

# MV PATIENT INFORMATION

Date: ____/____/____

Last Name: _____ First Name: _____ MI: ____ Gender: _____

Address: _____ Apt #:_____

City: _____ State: _____ Zip: _____

Cell #: _____ Email: _____ Date of Birth: ____/____/_____

Emergency Contact: _____ Phone #: _____

Height: _____ Weight:_____ LBS Are you currently pregnant? YES NO

## Occupational Information ( please circle all that pertain)

Employer: _____ Occupation: _____

Job involves: SITTING STANDING BENDING TWISTING

Physical Activity at Work: SEDENTARY LIGHT MANUAL LABOR HEAVY MANUAL LABOR

Have you missed work due to this accident: YES NO If yes, how many days? _____

## Symptoms since the accident ( please circle all that pertain)

| | | | | |
|---|---|---|---|---|
| Headaches | Pain in lower back | Knee Pain | Vertigo | Depression |
| Dizzy/Lightheaded | Pain in mid back | Rib Pain | Blurred Vision | Anxiety |
| Ringing in Ear | Pain in upper back | Chest Pain | Eye Strain | Insomnia |
| Grinding in Neck | Pain in hips | Knee Pain | Muscle Spasms | Memory Loss |
| Jaw problems | Pain in shoulder | Foot Pain | Grind Teeth | Nausea |
| Muscle spasms | Tingling in legs | Leg Pain | Light Sensitive | Fatigue |
| Sciatica | Sinus Pain | Neck Pain | Joint Stiffness | Sore Muscles |
| Numbness or tingling in feet/ legs | | Numbness or tingling in hands/arms | | |

## Please share any surgeries or traumas you've experienced:

_____

_____

WHAT MAKES THE PAIN BETTER? _____

WHAT MAKES THE PAIN WORSE? _____

Who have you seen for your symptoms and when?

Chiropractor: _____ Physical Therapist: _____

Medical Doctor: _____ Other: _____

CHIROPRACTIC
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# PATIENT HISTORY

NAME: _____ DOB: _____/_____/_____

**MEDICAL HISTORY**- *PLEASE CHECK ANY ISSUES EXPERIENCES BY YOU OR FAMILY MEMBERS.*

| | SELF | MOM | DAD | GP'S |
|---|---|---|---|---|
| ALCOHOL | | | | |
| ALLERGIES | | | | |
| ARTHRITIS | | | | |
| BLOOD PRESSURE | | | | |
| CANCER | | | | |
| CHOLESTEROL | | | | |
| CHRONIC FATIGUE | | | | |
| COLITIS | | | | |
| CONVULSIONS | | | | |
| DEPRESSION | | | | |
| DIABETES | | | | |
| DRUGS | | | | |
| FIBROMYALGIA | | | | |
| GASTRIC/REFLUX | | | | |
| HEADACHES | | | | |
| HEART DISEASE | | | | |
| HEPATITIS | | | | |
| HIV/AIDS | | | | |

| | SELF | MOM | DAD | GP'S |
|---|---|---|---|---|
| IBS | | | | |
| IMMUNE SYSTEM | | | | |
| LUNG DISEASE | | | | |
| LUPUS | | | | |
| MENTAL ILLNESS | | | | |
| MULTI. SCLEROSIS | | | | |
| MUSC. DYSTROPHY | | | | |
| OSTEOPOROSIS | | | | |
| RHEUM FEVER | | | | |
| SCARLET FEVER | | | | |
| SEIZURES | | | | |
| SHINGLES | | | | |
| SKIN DISORDERS | | | | |
| SLEEP DISORDERS | | | | |
| STROKE | | | | |
| THYROID DISEASE | | | | |
| VARICOSE VEINS | | | | |
| WEIGHT- GAIN/ LOSS | | | | |

PLEASE PUT AN X ON THE ACTIVITES YOU PARTICIPATE IN:

| | ACTIVITY | HOW OFTEN? | | | ACTIVITY | HOW OFTEN? |
|---|---|---|---|---|---|---|
| | DRIVING LONG DISTANCE | | | | SLEEP COMFORTABLY | |
| | EXERCISE | | | | SLEEP ON STOMACH | |
| | LIFT WEIGHTS | | | | TALK ON PHONE | |
| | PLAY SPORTS | | | | TRAVEL | |
| | YOGA/STRETCH | | | | SIT AT DESK | |

PLEASE LIST ALL CURRENT MEDICATIONS, INCLUDING VITAMINS AND SUPPLEMENTS:

_____ _____

_____ _____

_____ _____

_____ _____

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WELLNESS CENTER

# PATIENT INFORMATION

List current symptoms separately in order of severity.

1st Body Part: _____

How often do you experience this symptom? Constant Intermittent Rare
What makes symptom increase? _____
What makes symptom decrease? _____
Type of Pain? Sharp Dull Aching Burn Throb Numb
Please rate the intensity of your pain: *(0 being no symptoms, 10 being extreme)*
Where does pain radiate to? _____

2nd Body Part: _____

How often do you experience this symptom? Constant Intermittent Rare
What makes symptom increase? _____
What makes symptom decrease? _____
Type of Pain? Sharp Dull Aching Burn Throb Numb
Please rate the intensity of your pain: *(0 being no symptoms, 10 being extreme)*_____
Where does pain radiate to? _____

3rd Body Part: _____

How often do you experience this symptom? Constant Intermittent Rare
What makes symptom increase? _____
What makes symptom decrease? _____
Type of Pain? Sharp Dull Aching Burn Throb Numb
Please rate the intensity of your pain: *(0 being no symptoms, 10 being extreme)*_____
Where does pain radiate to? _____

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# ACCIDENT HISTORY

Patient's Name: _____ Date of Accident: _____

Where did the accident occur? *(Please give street names, city and state)* _____

_____

Please explain in detail how the accident happened: _____

_____

_____

_____

_____

## Accident Details *Please circle all that pertain to you*

**Road Conditions at time of Accident**: Wet Dry Snow Ice

**Road Surface**: Pavement Gravel Other_____

**Where were you seated in the vehicle**: Driver Passenger Rear-Seat

**Were you aware the collision was happening before impact**: Yes No

**Which direction was your head pointing at impact**: Straight Right Left Leaning Back

**Did any part of you strike**: Steering Wheel Dashboard Door Airbag

**Did you lose consciousness upon impact**: Yes No

**Were you wearing a seat belt**: Yes No **If Yes**: Shoulder Belt OR Lap Belt Only

**Did you go to the hospital**: Yes No **When?** _____

**What was their diagnosis?** _____ **Were X-rays done**: Yes No

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# AUTOMOTIVE INFORMATION

Who is responsible for the accident? _____

## Your car

Year: _____ Make: _____ Model: _____

Speed this vehicle was approximately going: _____

Name of driver for the automobile you were in: _____

Name of their auto insurance: _____

Phone Number of auto insurance: _____

## Other Car

Year: _____ Make: _____ Model: _____

Speed this vehicle was approximately going: _____

Name of driver for the automobile you were in: _____

Name of their auto insurance: _____

Phone Number of auto insurance: _____

## Claim Information

Claim Adjustor's Name: _____ Phone #: _____

Insurance Company filing claim with: _____

Claim #: _____ Policy #: _____

If you hired an attorney, Their Name: _____

Phone#: _____ Fax#: _____

CHIROPRACTIC
WELLNESS CENTER
3611 Main Street, Suite 103
Kansas City, Missouri 64111
816.561.7035 Phone
816.203.4819 Fax

**Frances M. Hollembaek, D.C.**
**Tyler Hoelting, D.C.**

To: _____
RE: _____
D/A: _____

I hereby give Dr. Frances M. Hollembaek a lien, pursuant to RSMo.430.225, on any benefits owed Chiropractic Wellness Center, whose address is 3611 Main St. Ste. 103, KCMO 64111 under the medical payments clause, uninsured motorist clause, or liability clause of my insurance policy.

I authorize and direct the above-named insurance company/attorney office to pay directly to Dr. Hollembaek her entire bill for professional services rendered

_____ - _____
Today's date Last date of treatment

by reason of the accident on the above date, as a result of the negligence or wrongful act of _____.
Person responsible for accident

The amount of the unpaid balance for the chiropractic services furnished to date is $_____. An itemized statement of the chiropractic services rendered and charges made therefore is attached to this notice and is duly incorporated and made a part hereof.

I also request and direct that any check or draft be paid to Dr. Hollembaek for said services be made out to Chiropractic Wellness Center and sent to 3611 Main St., Ste. 103, Kansas City, MO 64111.

Patient's Signature: _____ Date: _____

Printed Name:
_____

Witness:
_____

CHIROPRACTIC
WELLNESS CENTER

# CHIROPRACTIC INFORMED CONSENT

When a person seeks chiropractic health care and we accept someone for such care, it is essential for both the chiropractor and the patient to be working toward the same objective. Chiropractic has only one goal, to detect and reduce/correct misalignment. It is important that each person understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Treatment may involve adjustments, interferential current therapy, intersegmental traction therapy, cryotherapy, decompression therapy, hydro massage and therapeutic exercises. Risks may include but are not limited to cardiovascular, muscle ligament, joint or disc injury. Symptomatic aggravation of the condition is also possible. Risk factors have been reduced to the best of our ability. Any increase in the current levels of discomfort should be immediately reported to a staff member.

There are expected benefits associated with participation in a treatment program. They include*: increased flexibility, decreased pain, decreased inflammation, better circulation; all combining to improve function in activities of daily living.*

We do not offer to diagnose or treat any disease or condition other than misalignment. If during the course of a chiropractic evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider specializing in that area.

**Name of patient:** _____ **Date**: _____

**Patient's Signature**: _____

## PATIENT COMMUNICATION CONSENT

I agree to allow CHIROPRACTIC WELLNESS CENTER and staff to contact me in the following methods regarding my private health information, evaluation and treatment. I authorize CHIROPRACTIC WELLNESS CENTER to leave detailed messages for me when I am unavailable.

**Please select your preferred method of contact from our office where we can leave a detailed message.**

☐ Home Phone ☐ Cell Phone (Texting requires that you give us your cell number and for you to have a text enabled cell phone plan.)

☐ Work Phone ☐ Email

I authorize CHIROPRACTIC WELLNESS CENTER and staff to discuss my healthcare information (which may be history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below. I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

**Name:** _____

**Relationship to patient**: _____

By my signature below I acknowledge that I have read and understand the Guidelines to Patient Communication and information provided on this consent form. I understand the risk associated with the different methods of communication and consent to the conditions, restrictions and patient responsibilities outlined within the Guideline as well as any other instruction that CHIROPRACTIC WELLNESS CENTER may impose.

**Name of patient:** _____ **Date**: _____

**Patient's Signature**: _____

CHIROPRACTIC
WELLNESS CENTER

## FINANCIAL POLICY

We are pleased to accept your insurance assignment subject to verification of your coverage. We will file your claims as a courtesy to you. However, it must be fully understood that the contract is between you and your insurance company and **you are fully responsible for any amount not paid by your insurance.**

I accept assignment of benefits for medical payments to be made directly to Chiropractic Wellness Center.

I authorize the release of medical information necessary in the processing of my insurance claims.

I agree that I will pay the percentage of charges not covered by my insurance company at the time of service as deductible, coinsurance, copays.

I agree that I will pay in full for charges or services rendered by Chiropractic Wellness Center for either self-pay accounts or services that will not be covered by my insurance company, at the time they are incurred and, if for any reason my insurance company do not cover charges or a claim is denied, I will make payment arrangements immediately.

I agree that if my insurance company refuses to accept assignment of benefits or for some reason sends the payment to me, I will bring or send those payments to Chiropractic Wellness Center.

I understand and agree that Chiropractic Wellness Center will not enter into any dispute with my insurance company regarding a claim and that this is my responsibility and obligation.

I agree that a copy of this document can be considered the same as an original when used for insurance billing purposes.

I understand that I may be charged **$10 for no show appointments**. I will not be charged if I inform the office that I need to reschedule or cancel my appointment, by end of business day of my scheduled appointment. In our desire to be effective and fair to all of our clients and out of consideration to our doctor's time, we have adopted this following policy. The **$10** fee will be due before your next appointment.

By signing this document I certify that I have read and understand the financial policy of Chiropractic Wellness Center and agree it is true and accurate to the best of my knowledge. I authorize this office and its staff to examine and to treat my condition as the doctors see medically necessary. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment unless prior arrangements have been made.

**Name of patient:** _____ **Date:** _____

**Patient's Signature**: _____

## PHOTO RELEASE

Social media is a great way to spread the word about chiropractic care. Through photos and videos, we are able to share with others what exactly goes on here at Chiropractic Wellness Center.

If you are comfortable with us snapping photos of you occasionally and sharing on our social media, please sign the statement below. Please know that only your first name will be used and we promise to only use "flattering" pictures.

I give permission for Chiropractic Wellness Center to take pictures of my treatments and use on Chiropractic Wellness Center's social media pages.

**Name of patient:** _____

**Patient's Signature:** _____ **Date:** _____

CWCKCMO

# CHIROPRACTIC WELLNESS CENTER

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Chiropractic Wellness Center is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

**Disclosure of Your Health Care Information**

**Treatment**

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

*"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Chiropractic Wellness Center."*

*"It is our policy to provide a substitute health care provider, authorized by Chiropractic Wellness Center to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

**Payment**

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

*"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Chiropractic Wellness Center for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

**Workers' Compensation**

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

**Emergencies**

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

**Public Health**

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with and reactions to medications, and reporting disease or infection exposure.

**Judicial and Administrative Proceedings**

We may disclose your health information in the course of any administrative or judicial proceeding.

**Law Enforcement**

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

**Deceased Persons**

We may disclose your health information to coroners or medical examiners.

**Organ Donation**

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

**Research**

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board

**Public Safety**

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

**Specialized Government Agencies**

We may disclose your health information for military, national security, prisoner and government benefits purposes.

**Marketing**

We may contact you for marketing purposes of fundraising purposes, as described below: (example)

*"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time or your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."*

*"It is our practice to participate in charitable events to raise awareness, food donation, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Chiropractic Wellness Center sponsored fund-raising events."*

**Change of Ownership**

In the event that Chiropractic Wellness Center is sold or merged with another organization, your health information/record will become the property of the new owner.

**Your Health Information Rights:**

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however that Chiropractic Wellness Center is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Chiropractic Wellness Center amend your protected health information. Please be advised, however, that Chiropractic Wellness Center is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Chiropractic Wellness Center.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

**Changes to this Notice of Privacy Practices**

Chiropractic Wellness Center reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Chiropractic Wellness Center is required by law to comply with this Notice.

Chiropractic Wellness Center is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact our office at (816)-561-7035.

**Complaints**

Complaints about your Privacy rights or how Chiropractic Wellness has handled your health information should be directed to our office by calling (816)-561-7035. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights 200 Independence Avenue, S.W. Room 509F HHH Building Washington, DC 20201

This notice is effective April 14, 2003.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Chiropractic Wellness Center with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____

Patient's Name (print)

_____ _____

Patient's Signature Date

_____ _____

Authorized Facility Signature Date

CHIROPRACTIC
WELLNESS CENTER

PATIENT'S NAME: _____

DOB: _____ TODAY'S DATE: _____

| HEIGHT | | PT STANDING | L | R |
|---|---|---|---|---|
| WEIGHT | | HIGH MASTIOD | | |
| BP | | HIGH SHOULDER | | |
| PULSE | | HIGH HIP | | |
| DEMEANOR | | HEEL WALK (L4) | | |
| GEORGE'S | | TOE WALK (L5) | | |

| C-ROM | WNL | BNL | FINDINGS |
|---|---|---|---|
| FLEXION | 60 | | |
| EXTENSION | 60 | | |
| L. LAT FLEX | 45 | | |
| R.LAT FLEX | 45 | | |
| L ROTATION | 80 | | |
| R ROTATION | 80 | | |

| L-ROM | WNL | BNL | FINDINGS |
|---|---|---|---|
| FLEXION | 90 | | |
| EXTENSION | 30 | | |
| L. LAT FLEX | 35 | | |
| R. LAT FLEX | 35 | | |
| L ROTATION | 30 | | |
| R ROTATION | 30 | | |

| ORTHOS | L | R | FINDINGS |
|---|---|---|---|
| FOR COMP | + - | + - | |
| C-DISTRACT | + - | + - | |
| BRPI TENSION | + - | + - | |
| MAX C-COMP | + - | + - | |
| RUSTS | + - | + - | |
| JACKSONS | + - | + - | |

| DTR'S | L | R | FINDINGS |
|---|---|---|---|
| BICEPS | + - | + - | |
| BRACHIORAD | + - | + - | |
| TRICEPS | + - | + - | |
| PATELLAR | + - | + - | |
| ACHILIES | + - | + - | |
| BABINKSI | + - | + - | |

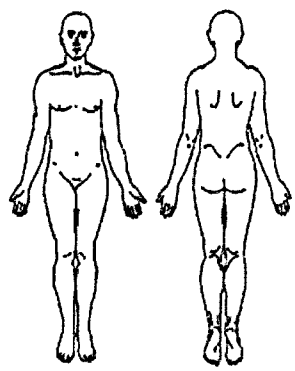
| ORTHO'S | L | R | FINDINGS |
|---|---|---|---|
| KEMPS | + - | + - | |
| BELT | + - | + - | |
| SLR | + - | + - | |
| BRAGGARD | + - | + - | |
| THOMAS | + - | + - | |
| FAERE | + - | + - | |
| MILGRIMS | + - | + - | |
| GOLDTHWAITS | + - | + - | |
| SOTO HALL | + - | + - | |
| NACHIAS | + - | + - | |
| ELYS | + - | + - | |
| HIBBS | + - | + - | |
| YOEMANNS | + - | + - | |

| UE ORTHO'S | L | R | FINDINGS |
|---|---|---|---|
| WRIGHTS | + - | + - | |
| APLEYS SCR SUP | + - | + - | |
| APLEYS SCR IF | + - | + - | |
| SPEEDS | + - | + - | |
| DAWBURNS | + - | + - | |
| COZENS | + - | + - | |
| REV COZENS | + - | + - | |
| FINKELSTEINS | + - | + - | |
| BRACELET | + - | + - | |

| LE ORTHO'S | L | R | FINDINGS |
|---|---|---|---|
| TRENDELBURG | + - | + - | |
| NOBELS | + - | + - | |
| ANT DRAWER KNEE | + - | + - | |
| POST DRAWER KNEE | + - | + - | |
| APLEYS COMP | + - | + - | |
| APLEYS DIST | + - | + - | |
| ANT DRAWER ANKLE | + - | + - | |
| POST DRAWER ANKLE | + - | + - | |

| HYPERTONIC MUSCLES | L | R | OTHER |
|---|---|---|---|
| SPLEN CERV | + - | + - | |
| SPLEN CAP | + - | + - | |
| TRAPEZIUS | + - | + - | |
| RHOMBOIDS | + - | + - | |
| LATS | + - | + - | |
| PARASPINALS | + - | + - | |
| QUAD LUMB | + - | + - | |
| GLUTS | + - | + - | |
| PIRIFORMIS | + - | + - | |
| HAMS | + - | + - | |
| QUADS | + - | + - | |

| LIST | L | R | LIST | L | R |
|---|---|---|---|---|---|
| C1 | | | T1 | | |
| C2 | | | T2 | | |
| C3 | | | T3 | | |
| C4 | | | T4 | | |
| C5 | | | T5 | | |
| C6 | | | T6 | | |
| C7 | | | T7 | | |
| | | | T8 | | |
| L1 | | | T9 | | |
| L2 | | | T10 | | |
| L3 | | | T11 | | |
| L4 | | | T12 | | |
| L5 | | | | | |
| | | | | | |
| SI | | | | | |
| PELV | | | | | |



**SYMPTOM DIAGRAM**

XXXXX= PAIN NNNN=NUMB
TTTTT=TINGLE AAAAA=ACHE
BBBBB=BURN SSSSS=SHARP

**LBDI=___% DI=___%**

Chiropractic Wellness Center

Name:_____ Date:_____

Treatment Plan:

3x/Week for _____ Weeks
2x/Week for _____ Weeks
1x/Week for _____ Weeks
2x/Month for _____ Months
1x/Month for _____ Months

Total Visits: _____

***E/M***

| | |
|---|---|
| Brief | ◻ New ◻ Established |
| Low | ◻ New ◻ Established |
| Moderate | ◻ New ◻ Established |
| High | ◻ New ◻ Established |

Decompression Plan:
◻ Yes ◻ No

**Cervical**

| | |
|---|---|
| ◻ Occiptal Seg Dysfunction | M99.00 |
| ◻ Cervical Seg Dysfunction | M99.01 |
| ◻ Cervicalgia | M54.2 |
| ◻ Cervicocranial Syndrome | M53.0 |
| ◻ Cervicobrachial Radiculitis | M53.1 |
| ◻ Radiculopathy, Cervical | M54.12 |
| ◻ Brachial Radiculitis, NOS | M54.13 |
| ◻ Occiptal Neuraligia | M54.81 |
| ◻ Migraine w/ Aura | G43.109 |
| ◻ Migraine w/o Aura | G43.009 |
| ◻ TMJ Adhesions | M26.61 |
| ◻ Cervical Sprain/Strain | S13.XXA |

**Lumbar**

| | |
|---|---|
| ◻ Lumbar Seg Dysfunction | M99.03 |
| ◻ Sacral Seg Dysfunction | M99.04 |
| ◻ Lumbago w/ Sciatica, Right | M54.41 |
| ◻ Lumbago w/ Sciatica, Left | M54.42 |
| ◻ Low Back Pain | M54.50 |
| ◻ Radiculopathy, Lumbar | M54.16 |
| ◻ Radiculopathy, Lumbosac | M54.17 |
| ◻ Radiculopathy, Sacral | M54.18 |
| ◻ Sciatica, Unspecified | M54.30 |
| ◻ Sciatica, Right side | M54.31 |
| ◻ Sciatica, Left side | M54.32 |
| ◻ Hip pain, RIGHT | M25.551 |
| ◻ Hip pain, LEFT | M25.552 |
| ◻ Lumbar Sprain/Strain | S33.5XXA |
| ◻ Sacroiliac Sprain/Strain | S33.6XXA |
| ◻ Pelvis Seg. Dysfunction | M99.05 |

**Thoracic**

| | |
|---|---|
| ◻ Thoracic Seg Dysfunction | M99.02 |
| ◻ Rib Seg Dysfunction | M99.08 |
| ◻ Thoracic Pain | M54.6 |
| ◻ Brachial Plexus Disorders | G54.0 |
| ◻ Radiculopathy, Thoracic | M54.14 |
| ◻ Radiculopathy, Thoracolumba | M51.05 |
| ◻ Shoulder Pain, RIGHT | M25.511 |
| ◻ Shoulder Pain, LEFT | M25.512 |
| ◻ Neuralgia & Neuritis, Unspec. | M79.2 |
| ◻ Thoracic Sprain/Strain | S23.XXA |

**Extremity/Other**

| | |
|---|---|
| ◻ Muscle Spasm, Back | M62.830 |
| ◻ Upper Ext Seg Dysfunction | M99.07 |
| ◻ Lower Ext Seg Dysfunction | M99.06 |
| ◻ Pain in elbow, RIGHT | M25.521 |
| ◻ Pain in elbow, LEFT | M25.522 |
| ◻ Pain in wrist, RIGHT | M25.531 |
| ◻ Pain in wrist, LEFT | M25.532 |
| ◻ Pain in knee, RIGHT | M25.561 |
| ◻ Pain in knee, LEFT | M25.562 |
| ◻ Ankle/foot joint pain, RIGHT | M25.571 |
| ◻ Ankle/foot joint pain, LEFT | M25.572 |

**Infant:**

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|---|---|
| ◻ Torticollis | M43.6 |
| ◻ Constipation | K59.00 |
| ◻ Sleep Disrupt | G47.9 |

Any diagnosis not listed, to be coded:

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