TOMBALL CHIROPRACTIC CENTER
27030 TOMBALL PARKWAY
TOMBALL, TEXAS 77375
281-351-7272 (p) 281-351-7274 (f)

MAGNOLIA SPINE AND REHAB
827 S. MAGNOLIA BLVD #2
MAGNOLIA, TEXAS 77355
281-356-6300 (p) 281-356-6321 (f)

PATIENT NAME ______________________________ DATE OF BIRTH ____/____/______ AGE ______

ADDRESS ______________________________ APT# ____ CITY ______________ STATE ____ ZIP ________

HOME PH # ____________________ CELL ________________ EMAIL ______________________________

SOCIAL SECURITY # ______________________ MARITAL STATUS: M S D W # OF CHILDREN ____

SPOUSE'S NAME ______________ EMERGENCY CONTACT AND PHONE # ______________________________

YOUR EMPLOYER ______________________ OCCUPATION ______________________________

SECTION A: WORK / AUTO ACCIDENT / PERSONAL INJURY INFORMATION

Date of Injury __________________ Area(s) of Injury ______________________________

How did the injury occur?

____

Were you evaluated at an ER or by another doctor for your injuries? Yes or No If yes, Where? ______________

Taken by ambulance? Yes or No Were x-rays or other diagnostic imaging taken? Yes or No

Were medications prescribed? Yes or No Are you taking those medications? Yes or No

Did you lose consciousness when these injuries occurred? Yes or No

Did you have any: (Circle) Cuts / Scratches / Bruises / Fractures

Were you the: (Circle one) Driver / Front seat passenger / Back seat passenger

SECTION B: SYMPTOM SPECIFIC INFORMATION

Overall, would you describe your symptoms as: (Circle one)
Mild / Mild to Moderate / Moderate / Moderate to Severe / Severe

How often do you experience these symptoms: (Circle one)
Occasionally / Occasional to Frequent / Frequently / Frequent to Constant / Constantly

Since onset, have your symptoms: (Circle one)
Improved / Gotten Worse / Stayed about the same / Changes daily

Describe your symptoms:
Tingling / Numbness / Sharp / Burning / Dull / Shooting / Cramping / Other ______________________________

Have you missed work due to these symptoms? Y or N
Are you currently off of work due to these symptoms? Y or N

SECTION C: TREATMENT COMPLIANCE POLICY

Following your evaluation and examination today, our doctors may establish a treatment plan for you with regard to your specific injuries and/or complaints. The outcome of your treatment could be negatively affected by your inability or unwillingness to abide by and/or maintain the proposed course of treatment. Just as you expect our office to be considerate of your time, we ask for the same courtesy. If you are unable to make a scheduled appointment, please contact our office so that we may provide another patient with that timeslot. Success with your treatment in our office is our primary concern and compliance with our treatment plan is essential to that process. Please let us know if other factors, such as scheduling or financial issues are likely to interfere with your compliance.

SECTION D: AUTHORIZATION TO RELEASE MEDICAL RECORDS

- I hereby authorize the release of all my medical records to Tomball Chiropractic Center and Magnolia Spine & Rehab where necessary or as required for the purposes of my examination and/or treatment.
- I further authorize payment be made directly to Tomball Chiropractic Center and Magnolia Spine & Rehab, as an assignment of my benefits, for services rendered that would otherwise be payable to me.
- I agree that in the event my outstanding bills are unpaid by a third-party source, I am responsible for payment of all services performed. I have read and understand the above statements and attest that the information I have provided is correct.

PATIENT SIGNATURE ______________________________ DATE ______________________________

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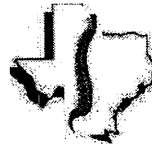


MAGNOLIA SPINE AND REHAB
827 S. MAGNOLIA BLVD #2
MAGNOLIA, TEXAS 77355
281-356-6300 (p) 281-356-6321 (f)

PATIENT HISTORY

Ht: _____ Wt: _____ BP: _____ Pulse____

Name: ______________________________ Date: ______________

Medical History: Do you have a history of:

		Resolved	Treating
Diabetes	Y / N	☐	☐
High Blood Pressure	Y / N	☐	☐
Heart Disease	Y / N	☐	☐
Stroke	Y / N	☐	☐
Cancer (type)______________	Y / N	☐	☐
Thyroid Disease	Y / N	☐	☐
AIDS / HIV	Y / N	☐	☐
Hepatitis (type) ______________	Y / N	☐	☐
Rheumatoid Arthritis	Y / N	☐	☐
Asthma	Y / N	☐	☐
Osteoporosis	Y / N	☐	☐
Osteopenia	Y / N	☐	☐
COPD	Y / N	☐	☐
Pacemaker	Y / N	☐	☐
Defibrillator	Y / N	☐	☐
Kidney Stones	Y / N	☐	☐
Kidney Infections	Y / N	☐	☐
Urinary tract Infections	Y / N	☐	☐
Ulcers	Y / N	☐	☐
GI Problems	Y / N	☐	☐

Past Surgical / Hospitalization History
Please list: (For What / When / Where / Who)

____

____

____

Family History
Has anyone in your family had any of the following:

Diabetes	Y or N
Heart Disease	Y or N
Stroke	Y or N
Cancer (type)______________	Y or N

Social History
Do you use:

Tobacco products	Y or N
Alcohol	Y or N
Recreational drugs	Y or N

What is your current activity / exercise level?
Sedentary / Moderate / Very Active

Are you pregnant? Y or N Maybe

Current Medications
Please list medications you are taking and the reason:

____

____

____

____

Drug Allergies
Please list:

____

Review of Systems
Do you have any of the following symptoms:

Depression	Y or N
Anxiety	Y or N
Fever	Y or N
Unexplained Weight Loss	Y or N
Chest Pain	Y or N
Irregular Heart Beat	Y or N
Poor Circulation	Y or N
Blood in Urine	Y or N
Difficulty with Urination	Y or N
Headaches	Y or N
Radiating Pain	Y or N
Decreased / Blurred Vision	Y or N
Shortness of Breath	Y or N
Persistent Cough	Y or N
Ringing in your Ears	Y or N
Hearing Loss	Y or N
Throat Pain	Y or N
Sinus Pressure	Y or N
Stomach / Abdominal Pain	Y or N
Change in Bowel or bladder Function	Y or N
Nausea	Y or N
Vomiting	Y or N
Dizziness	Y or N
Tingling	Y or N
Numbness	Y or N
Joint Swelling	Y or N
Muscle Ache	Y or N
Joint Pain	Y or N
Neck Pain	Y or N
Back Pain	Y or N
Pain with Movement	Y or N
Trouble Sleeping Due to Pain	Y or N

Are you currently being treated or have you recently been treated by another physician for any of these symptoms? Y or N – Who? ______________

What is/was the nature of that treatment? ___________

____

HIPAA 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.**

Uses and Disclosures

Some examples of how we may use or disclose your healthcare information:

- Your chiropractor or a staff member may disclose your health information to another healthcare provider, hospital, or treatment facility in order to refer you for diagnosis, assessment, treatment, or testing.
- Your chiropractor or a staff member may disclose your health information, including your billing records, to another party such as an insurance carrier, an HMO, a PPO, or your employer or their insurance carrier, if they are potentially responsible for the payment of the services you receive.
- Your chiropractor or a staff member may disclose your health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voicemail, or with the person who answers the call.
- You have the right to refuse us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you refuse us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.
- At any time, you may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information.

Permitted Uses and Disclosures Without Your Consent or Authorization

Under Federal law, we are permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- We are permitted to use or disclose your health information when required to do so by applicable federal or state laws.
- We are permitted to use or disclose your health information to a public health authority for a wide range of public health activities when the public health authority is authorized to collect or receive your health information to under state or federal law.
- We are permitted to use or disclose your health information to an appropriate governmental authority if we reasonably believe you are the victim of abuse, neglect, or domestic violence.
- We are permitted to use or disclose your health information for state and federal health oversight activities of the healthcare system and government benefit programs.
- We are permitted to use or disclose your health information in response to a court order or in response to a subpoena, discovery request, or other lawful purpose.
- We are permitted to use or disclose your health information to a law enforcement authority as required by laws to report certain types of wounds or physical injuries or to comply with a court order, subpoena, or administrative request authorized by law.
- We are permitted to use or disclose your health information to a law enforcement authority if the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- We are permitted to use or disclose your health information to a correctional institution if we provide healthcare services to you as an inmate.
- We are permitted to use or disclose your health information if we provide healthcare services to you in an emergency.
- We are permitted to use or disclose your health information if we provide care to you that is related to a workplace injury to the extent necessary to comply with Workers' Compensation rules and regulations.

Your Right to Revoke Your Authorization

You may revoke your authorization to us at anytime; however, your revocation must be in writing. Your revocation request will not be honored if:

- We have already released your health information before we receive your request to revoke your authorization.
- You were required to give your authorization as a condition of obtaining insurance; the insurance company may have a right to your health information if they decide to contest any of your claims.
- Any circumstance in which we are permitted or required to use or disclose your health information without your consent or authorization.

Your Right to Limit Use or Disclosure

If there are healthcare providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know in writing which providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your healthcare information. We are not required to agree to your restriction; however, if we agree with your restriction, the restriction is binding on us. If we do not agree to your restriction, you may seek care from another healthcare provider.

Other than the circumstances described above, any other use or disclosure of your health information will only be made with your written authorization.

Patient Signature: ______________________ Date:______________

Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing. We may refuse your request if the information is for use in a civil, criminal, or administrative action or proceeding which is anticipated to occur in a time frame reasonable proximate to your request. There may be a cost associated with your request if we must copy information for you.

Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:

- those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
- those disclosures made to you.
- those disclosures we are permitted to make without your consent or authorization as described above.
- those disclosures made based on an authorization you signed.
- those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- those disclosures for national security or intelligence purposes.
- those disclosures made to correctional officers or law enforcement officers.
- those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your right to obtain a paper copy of this notice

If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

Our duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your right to complain

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be sent to us at the address listed below.

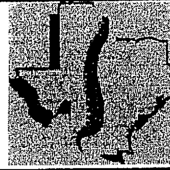
To contact us

If you would like further information about our privacy policies and practices please contact:

Dr. Devin Pettiet, D.C
27030 Tomball Parkway
Tomball, Texas 77375

______________________________ Patient Signature   ____________ Date

Tomball Chiropractic Center
27030 Tomball Parkway
Tomball, Texas 77375
Phone: 281-351-7272
Fax: 281 - 351-7274



Magnolia Spine and Rehab
827 S. Magnolia Blvd Ste 2
Magnolia, Texas 77355
Phone: 281-356-6300
Fax: 281 - 356-6321

To: Patients of Tomball Chiropractic Center and Magnolia Spine and Rehab

We specialize in the treatment of the spine, joint injuries, and associated pain. We perform various treatments consisting of passive modalities, therapeutic interventions, and spinal and extra-spinal manipulation. Our goal is to reduce and/or eliminate your pain, however, as with any Chiropractic or any physical medicine therapies there are inherent risks with the services we provide.

Passive Modalities: We use a variety of widely used therapeutic devices to complement our chiropractic treatments including: interferential therapy, ice, moist heat, ultrasound, and cervical and lumbar traction. These modes of therapy are used to help reduce pain and inflammation, among other things.

The primary risk associated with passive modalities is skin irritation due to exposure to hot or cold agents used in the application of modalities, i.e. lotions, pads, paraffin, ice, or moist heat. If you have experienced skin sensitivity to hot or cold temperatures and/or similar lotions or products, please make us aware prior to treatment.

Therapeutic Interventions: Therapeutic interventions consist of stretching, flexibility and strengthening exercises, range of motion exercises, joint mobilization and myofascial release.

These activities are generally very safe though there are risks associated with each. The primary risk is potential aggravation of your condition. As with any physical activity there is always the risk of injury. Though this risk is minimal it may still exist.

Some adverse responses to therapeutic interventions include, but are not limited to: muscle soreness, bruising, muscle fatigue, increased pain and discomfort, and/or joint stiffness. It is important that you inform your treating staff member of any of these responses and more importantly it is crucial that you attend all of your scheduled appointments so that changes in your condition can be accurately documented and your symptoms effectively managed.

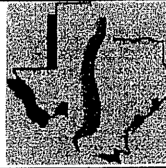
Spinal and Extra-spinal Manipulation: Chiropractic manipulation seeks to restore joint function to the spine and other joints of the body. Typically, this involves applying a specific, highly controlled treatment directly to a joint or muscle. This treatment often reduces and/or eliminates both local and referred pain, allows muscles to relax, and may even release the irritation from the nervous system, which may result in other health benefits. The following are some risks of manipulation:

- **Disc Herniations:** The occurrence of disc herniations as a result of spinal manipulation is very unlikely. Discs withstand an average of 23 degrees of rotation and a degenerative disc an average 14 degrees. Posterior facets of the spine limit rotation during manipulation to approximately 2-3 degrees.
- **Cauda Equina Syndrome:** The estimated incident rate of this complication as a result of lumbar manipulation is approximately 1 in 100 million manipulations. The likelihood of this occurrence is possibly increased with the presence of herniated nucleus pulposus.
- **Vertebrobasilar Artery Compromise:** Chiropractic manipulation has been shown in isolated cases to result in stroke as a result of desiccation of the vertebral artery. The likelihood of such an event has been estimated at 1 in 1,000,000 cervical manipulations (Hurwitz, 1996; McGregor, 1995). Possible symptoms of stroke include, but are not limited to: dizziness, light-headedness, numbness, slurred speech, loss of consciousness, and memory or comprehension disturbances. If you have any of these symptoms following cervical manipulation, please contact us and/or seek immediate emergency medical treatment.

I have reviewed the information provided above regarding the benefits and risks of treatment provided in our offices. I have been given the opportunity to ask questions and/or discuss concerns. I acknowledge and accept the risks of my treatment.

______________________	______________________	______________
Patient Name	Patient Signature	Date

Tomball Chiropractic Center
27030 Tomball Parkway
Tomball, Texas 77375
Phone: 281-351-7272
Fax: 281 - 351-7274



Magnolia Spine and Rehab
827 S. Magnolia Blvd Ste 2
Magnolia, Texas 77355
Phone: 281-356-6300
Fax: 281 - 356-6321

What to do and expect after therapy

We utilize a variety of different therapeutic methods to treat our patients and their injuries including: interferential therapy, myofascial release, therapeutic exercise, ultrasound, moist heat, ice, paraffin, and traction. While the immediate goal of therapy is pain reduction, you may experience increased levels of pain during the initial phases of care. The following are common, non-complicating responses to therapy: soreness, bruising, stiffness, increased pain, decreased joint mobility, and weakness.

If any of the above-mentioned responses occur or if anything arises which causes you concern, please tell one of our staff as soon as possible. While such results are common, they need to be documented and possible changes made to your treatment protocol.

Home Care: In order to reduce the likelihood that an adverse reaction occurs, we have provided you with a list of things to do at home.

- **Use ice** – Ice is an amazing anti-inflammatory. Myofascial release is a frequently used therapy in our office. Its function is to reduce muscle spasm, increase muscle function, and reduce scar tissue formation. Myofascial release is an intense therapy that may result in bruising and increased soreness. To reduce the likelihood of an adverse reaction from any therapy, please use ice and increase your water consumption.
- **Stretch** – We always advise that you incorporate stretching into your daily routine, unless otherwise advised by Dr. Pettiet. Stretching will help your muscles stay loose and will reduce the stress on your joints.
- **Keep your appointments** – Your treatment plan requires that you stay consistent with your therapy. This will help minimize the number of therapy sessions and maximize your therapeutic gains. Keeping up with scheduled appointments also allows us to accurately track your progress.
- **Avoid activities that may aggravate your injury/condition** – Some injuries need to be fixed before they can be rehabilitated. You may do more harm than good if you choose to participate in activities that we find contrary to your care. Activities of daily living may prove to be too much. You are less likely to suffer a serious setback if you are cautious and increase your activity level gradually.

In case of emergency: If a situation arises where you experience a serious adverse reaction to care or a significant side-effect which you feel requires emergency medical attention, then go to the closest emergency care center or call 911. Contact our office as soon as possible and keep us informed.

If you ever have questions concerning your injury or treatment, please do not hesitate to ask us.

Thank you,

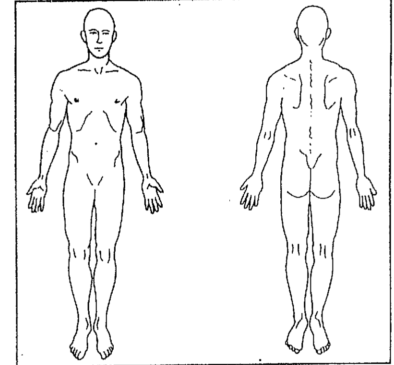
Dr. Devin Pettiet, D.C.

________________	________________	__________
Patient Name	Patient Signature	Date

Tomball Chiropractic Center | Magnolia Spine and Rehab

Patient Name: ______________________ Date: ______________________

Circle your areas of pain



1. Do you have any new issues or concerns to report? Yes or No
   If Yes, explain: ______________________
2. Are you working under restricted duty? Yes or No or Not working
3. Since the initiation of treatment, has your condition: (Circle one)
   Doesn't Apply (First Visit for this Issue) Improved Worsened No Change
4. Since your last visit, has your condition: (Circle one)
   Improved Worsened No Change
5. Does your pain increase with specific activities? Yes or No
   If Yes, which ones? ______________________
6. Are you using other remedies to reduce your pain levels (medications/ice/heat/TENS/etc.)? Yes or No
7. What medications are you taking for pain? ______________________

Patient Signature ______________________

E/M Counseling / Clinical Notes

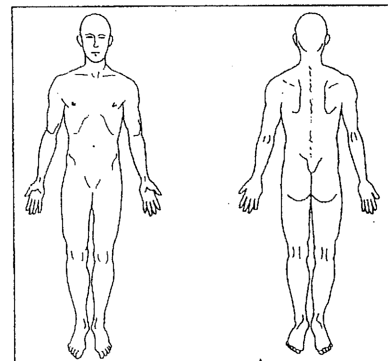
Subject

Objective

Impression / Diagnosis

Plan / Goals / Referrals

Notes



Face-to-face time spent counseling / educating the patient

☐

Dr. Signature: ______________________

Therapist: ______________________

Any adverse reactions to last treatment Yes or No

Manipulation

C ____ T ____ L ____ Sacral ____ Pelvis (SI) ____
TMJ ____ Lower Ex ____ Upper Ex ____ Rib/Clavicle ____

Electric Stimulation

	Area	Intensity
☐	Cervical	____
☐	Thoracic	____
☐	Lumbar	____
☐	____	____
☐	____	____

Myofascial / Manual Therapy

	Area	Time (minutes)
☐	____	____

Ultrasound

	Area	Time (minutes)
☐	____	____

Mechanical Traction / Intersegmental Traction

☐ Cervical / Lumbar

Rehab

		Area(s)	Description	Time(min)
☐	ROM:	____	____	____
☐	Stretching:	____	____	____
☐	Bicycle:	____	____	____
☐	Upper Ex Cycle:	____	____	____
☐	Treadmill:	____	____	____
☐	Strengthening:	____	____	____

Home Care Protocol and Recommendations:

Any adverse reactions to today's treatment? Yes or No

NEW PATIENT OFFICE VISIT
- ❑ 99204 – 25 COMPREHENSIVE
- ❑ 99203 – 25 DETAILED
- ❑ 99202 – 25 EXPANDED/PROBLEM FOCUSED
- ❑ 99201 – 25 PROBLEM FOCUSED

ESTABLISHED PATIENT OFFICE VISIT
- ❑ 99214 – 25 DETAILED
- ❑ 99213 – 25 EXPANDED/PROBLEM FOCUSED
- ❑ 99212 – 25 PROBLEM FOCUSED
- ❑ 99211 – 25 MINIMAL

CHIROPRACTIC MANIPULATION
- ❑ 98940 1 TO 2 REGIONS
- ❑ 98941 3 TO 4 REGIONS
- ❑ 98943 EXTREMITY

THERAPY

	Code	Service	UNITS
❑	97140	MYOFASCIAL/MANUAL THERAPY	______
❑	97124	MASSAGE	______
❑	97014	E-STIM (UNATTENDED)	______
❑	G0283	E-STIM (MEDICARE/UHC/WC)	______
❑	97035	ULTRASOUND	______
❑	97110	REHAB (DIRECT)	______
❑	97150	REHAB (SUPERVISED)	______
❑	97012	MECHANICAL TRACTION	______
❑	97010	ICE/HEAT	______
❑	______________		______

RADIOLOGY
- ❑ 72040 CERVICAL 2-VIEW
- ❑ 72050 CERVICAL 4-VIEW (W/ OBL)
- ❑ 72100 LUMBAR 2-VIEW
- ❑ 72110 LUMBAR 4 VIEW (W/ OBL)
- ❑ 72070 THORACIC 2-VIEW
- ❑ 73030 SHOULDER 2-VIEW
- ❑ 73100 ELBOW 2-VIEW
- ❑ 73120 WRIST 2-VIEW
- ❑ 73100 HAND 2-VIEW
- ❑ 73510 HIP 2-VIEW
- ❑ 73560 KNEE 2-VIEW
- ❑ 73630 FOOT/ANKLE 2-VIEW

OTHER: ______________________________

MISC PURCHASE
- ❑ TENS / EMS TOS / INSURANCE
- ❑ CERVICAL TRACTION
- ❑ BIOFREEZE

OTHER: ______________________________

NEXT APPT:
3X WK / 2X WK / 1X WK / 1 WK / 2WK / 1MO
MON / TUES / WED / THURS / FRI

DR. SIGNATURE: ______________________

THERAPIST:

DIAGNOSIS CODES

- ❑ **847.0 CERVICAL S/S**
- ❑ 723.1 CERVICAL PAIN
- ❑ 739.1 CERVICAL SEG DYSF
- ❑ 719.48 ARTHRALGIA – SPINE
- ❑ **723.8 FACET SYND - CERVICAL**
- ❑ 722.4 CERVIAL DEG DISC
- ❑ 723.3 CERVICOBRACHIO SYN
- ❑ **722.0 CERVICAL HNP**
- ❑ 724.9 FORAMINAL ENCROACH
- ❑ **723.4 CERVICAL RAD**
- ❑ 722.81 C/S POST LAMIN SYN
- ❑ 719.58 STIFFNESS – SPINE
- ❑ 724.5 BACK PAIN UNSPEC.
- ❑ 719.68 CREPITUS – SPINE
- ❑ 805.10 COMPRESSION FX – C/S

- ❑ **784.0 CERVICOGENIC HA**
- ❑ 346.90 MIGRAINE
- ❑ 339.10 TENSION HA

- ❑ **847.1 THORACIC S/S**
- ❑ 905.7 LATE EFFECTS OF S/S
- ❑ **724.1 THORACIC PAIN**
- ❑ 739.2 THORACIC SEG DYSF
- ❑ 719.48 ARTHALGIA - SPINE
- ❑ 722.51 THORACIC DEG DISC
- ❑ 722.11 THORACIC HNP
- ❑ 724.9 FORAMINAL ENCROACH
- ❑ 724.4 THORACIC RAD
- ❑ 353.0 THORACIC OUTLET
- ❑ 719.58 STIFFNESS – SPINE
- ❑ **724.5 BACK PAIN UNSPEC**
- ❑ 805.2 COMPRESSION FX T/S
- ❑ 922.1 CHEST CONTUSION
- ❑ 922.0 BREAST CONTUSION

- ❑ 729.4 MYOFACIITIS UNSPEC
- ❑ 729.1 MYOFASCIAL SYND
- ❑ **728.85 MUSCLE SPASM**

ADD / CHANGE

- ❑ **847.2 LUMBAR S/S**
- ❑ 905.7 LATE EFFECTS OF S/S
- ❑ 719.48 ARTHRALGIA - SPINE
- ❑ 722.52 LUMBAR DEG DISC
- ❑ **722.10 LUMBAR HNP**
- ❑ 724.2 LUMBAR PAIN
- ❑ 724.3 SCIATICA
- ❑ **724.4 LUMBAR RAD**
- ❑ 724.5 BACK PAIN UNSPEC
- ❑ **724.8 FACET SYND - LUMBAR**
- ❑ 724.9 FORAMINAL ENCROACH
- ❑ 722.83 L/S POST LAM SYND
- ❑ 805.4 COMPRESSION FX – L/S
- ❑ 719.58 STIFFNESS – SPINE
- ❑ 739.3 LUMBAR SEG DYSF
- ❑ **720.2 SACROILIITIS**
- ❑ 719.45 PAIN SACROILIAC

- ❑ 924.01 HIP CONTUISON
- ❑ **726.5 ENTHESOPATHY HIP**
- ❑ 719.45 PAIN - HIP / PELVIS
- ❑ 715.95 DJD – HIP
- ❑ 719.55 STIFFNESS HIP/PELVIS
- ❑ 924.11 KNEE CONTUSION
- ❑ **844.9 KNEE S/S**
- ❑ 717.9 INT DERANG – KNEE
- ❑ **845.00 ANKLE S/S**
- ❑ 728.71 PLANTAR FASCIITIS.
- ❑ 715.96 DJD – KNEE
- ❑ **719.46 PAIN – KNEE**
- ❑ 719.47 PAIN – ANKLE / FOOT
- ❑ 729.5 LIMB PAIN UNSPEC
- ❑ 924.5 LEG CONTUSION
- ❑ 355.71 CAUSALGIA – LOWER

- ❑ 737.10 KYPHOSIS (ACQ)
- ❑ 737.20 LORDOSIS (ACQ)
- ❑ 738.2 HYPOLORDOSIS C / L

Intake sticker

- ❑ **840.9 SHOULDER S/S**
- ❑ 840.0 A/C JOINT S/S
- ❑ 840.8 ROTATOR CUFF S/S
- ❑ **726.10 ROTATOR CUFF SYND**
- ❑ 726.12 BICIPITAL TENDONITIS
- ❑ 727.61 ROT CUFF RUPTURE
- ❑ 840.7 SLAP LESION
- ❑ 719.41 SHOULDER PAIN
- ❑ 726.0 ADHESIVE CAPSULITIS
- ❑ 726.19 SHOULDER BURSITIS
- ❑ 726.31 MED EPICONDYLITIS
- ❑ 726.32 LAT EPICONDYLITIS
- ❑ 714.44 WRIST/HAND PAIN
- ❑ 842.00 WRIST S/S (UNSPEC)
- ❑ 842.10 HAND S/S (UNSPEC)
- ❑ 354.0 CARPAL TUNNEL
- ❑ 729.5 LIMB PAIN UNSPEC
- ❑ 354.4 CAUSALGIA – UPPER

- ❑ 310.2 POST-CONCUSSION
- ❑ V71.4 MVA EXAM – NO DX
- ❑ V54.89 POST-OP REHAB ORTH
- ❑ V58.78 POST-OP REHAB SURG
- ❑ V58.43 ROTATOR CUFF REPAIR

- ❑ **736.81 LEG LENGTH (ACQ)**
- ❑ 781.9 ABNORMAL POSTURE
- ❑ 738.4 SPONDYLOLISTHESIS (ACQ)
- ❑ 337.21 REFLEX SYMP DYSTROPHY