

### PATIENT DEMOGRAPHICS

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PMID#: \_\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Names and Ages of Children: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Marital Status:  Single  Married Do you have Insurance:  Yes  No Primary Insurance: \_\_\_\_\_

Secondary Ins. \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

### HISTORY of COMPLAINT

*Please identify the condition(s) that brought you to this office:*

Health Concerns: List according to severity worst to best	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

CHIROPRACTOR? \_\_\_\_\_ MEDICAL DOCTOR? \_\_\_\_\_ OTHER (WHO)? \_\_\_\_\_

How long were you under care: \_\_\_\_\_ What were the results? \_\_\_\_\_

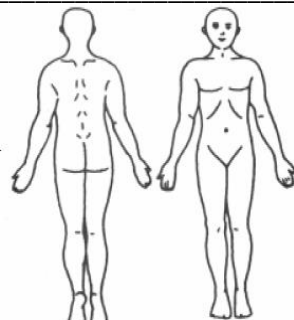
Name of Previous Chiropractor: \_\_\_\_\_  N/A

**\*PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

**R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/ Stabbing T= Tingling**

What relieves your symptoms? \_\_\_\_\_

What makes them feel worse? \_\_\_\_\_



**Please mark P for in the Past, C for Currently (Leave Blank for Never)**

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> Headache                           | <input type="checkbox"/> Pregnant (Now)         | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Prostate Problems        | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Neck Pain                          | <input type="checkbox"/> Frequent Colds/Flu     | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Impotence/Sexual Dysfun. | <input type="checkbox"/> Heartburn            |
| <input type="checkbox"/> Jaw Pain, TMJ                      | <input type="checkbox"/> Convulsions/Epilepsy   | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Digestive Problems       | <input type="checkbox"/> Heart Problem        |
| <input type="checkbox"/> Shoulder Pain                      | <input type="checkbox"/> Tremors                | <input type="checkbox"/> Double Vision   | <input type="checkbox"/> Colon Trouble            | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Upper Back Pain                    | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Blurred Vision  | <input type="checkbox"/> Diarrhea/Constipation    | <input type="checkbox"/> Low Blood Pressure   |
| <input type="checkbox"/> Mid Back Pain                      | <input type="checkbox"/> Pain w/Cough/Sneeze    | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Menopausal Problems      | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Low Back Pain                      | <input type="checkbox"/> Foot or Knee Problems  | <input type="checkbox"/> Hearing Loss    | <input type="checkbox"/> Menstrual Problem        | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain                           | <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> Depression      | <input type="checkbox"/> PMS                      | <input type="checkbox"/> Lung Problems        |
| <input type="checkbox"/> Back Curvature                     | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Irritable       | <input type="checkbox"/> Bed Wetting              | <input type="checkbox"/> Kidney Trouble       |
| <input type="checkbox"/> Scoliosis                          | <input type="checkbox"/> Skin Problems          | <input type="checkbox"/> Mood Changes    | <input type="checkbox"/> Learning Disability      | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers |   | <input type="checkbox"/> ADD/ADHD        | <input type="checkbox"/> Eating Disorder          | <input type="checkbox"/> Liver Trouble        |
| <input type="checkbox"/> Numb/Tingling legs, feet, toes     |   | <input type="checkbox"/> Allergies       | <input type="checkbox"/> Trouble Sleeping         | <input type="checkbox"/> Hepatitis (A,B,C)    |

List any prescription and non-prescription medications you are taking:

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

### PAST HISTORY

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have and **N** for **Never have had**:

\_\_\_ Broken Bone \_\_\_ Dislocations \_\_\_ Tumors \_\_\_ Rheumatoid Arthritis \_\_\_ Fracture \_\_\_ Disability \_\_\_ Cancer  
\_\_\_ Heart Attack \_\_\_ Osteo Arthritis \_\_\_ Diabetes \_\_\_ Cerebral Vascular \_\_\_ Other serious conditions:

**PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:**

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES	→		
SURGERIES	→		
CHILDHOOD DISEASES	→		
ADULT DISEASES	→		

### SOCIAL HISTORY

- Smoking:**  cigars  pipe  cigarettes → How often?  Daily  Weekends  Occasionally  Never
- Alcoholic Beverage:** consumption occurs →  Daily  Weekends  Occasionally  Never
- Recreational Drug use:**  Daily  Weekends  Occasionally  Never
- Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect the following:

### FAMILY HISTORY:

- Does anyone in your family suffer with the same condition(s)?  No  Yes  
If yes whom:  grandmother  grandfather  mother  father  sister's  brother's  son(s)  daughter(s)  
Have they ever been treated for their condition?  No  Yes  I don't know
- Any other hereditary conditions the doctor should be aware of.  No  Yes: \_\_\_\_\_

## ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

**ACTIVITIES:**

**EFFECT:**

Carrying Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting Children	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Reading/Concentration	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
OTHER: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

Patient signature: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_

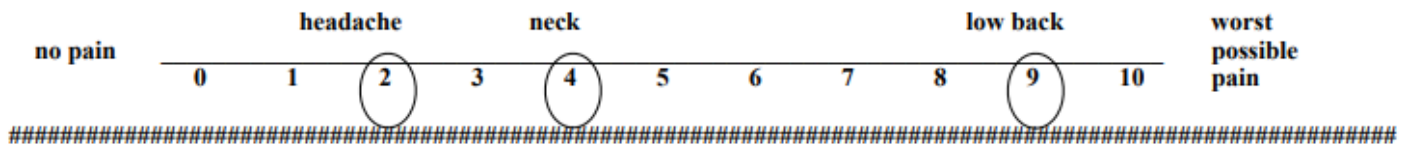
Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## QUADRUPLE VISUAL ANALOGUE SCALE

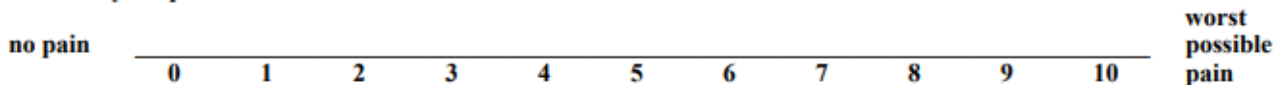
**INSTRUCTIONS:** Please circle the number that best describes the question being asked.

**NOTE:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

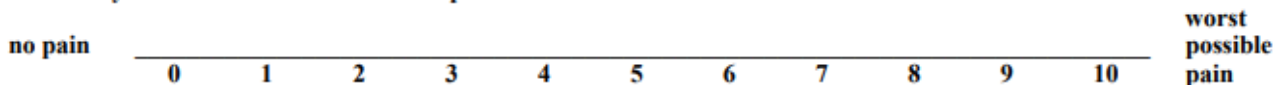
**EXAMPLE:**



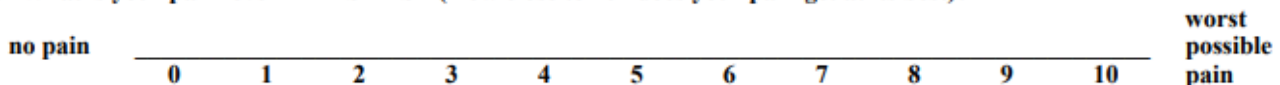
**1. What is your pain RIGHT NOW?**



**2. What is your TYPICAL or AVERAGE pain?**

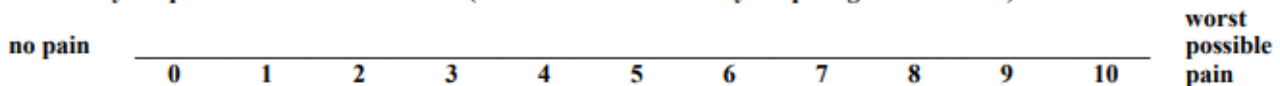


**3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?**



What percentage of your awake hours is your pain at its best? \_\_\_\_\_%

**4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?**



What percentage of your awake hours is your pain at its worst? \_\_\_\_\_%

# INFORMED CONSENT

**REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures**

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Life Force Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient or Authorized Person's Signature              Date

**REGARDING: Written Consent for a Minor/Child**

**NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD:** \_\_\_\_\_

I authorize Dr. Kyle Kurscheidt, Dr. Cody Kurscheidt, Dr. Tiffany Thorne, and any and all Life Force Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care, and perform chiropractic adjustments to my minor/child. As of this date, I have legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Life Force Chiropractic.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Guardian's Signature    Date

\_\_\_\_\_  
Guardian's Relationship to Minor/Child

**REGARDING: X-Rays/Imaging Studies**

### X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.

AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAY FILMS.

**THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS \$15.00. THIS FEE MUST BE PAID IN ADVANCE.**

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY.

**PLEASE NOTE:** X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS.**

THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF LIFE FORCE CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

**BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient or Authorized Person's Signature                      Date

**REGARDING: X-Rays/Imaging Studies -- FEMALE PATIENTS ONLY**

*Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

The first day of my last menstrual cycle was on \_\_\_/\_\_\_/\_\_\_ (Date)

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am NOT PREGNANT at the time x-rays are taken at Life Force Chiropractic.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient or Authorized Person's Signature                      Date

## TERMS OF ACCEPTANCE

In order to provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
- C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
- D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
- E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health.
- G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

I hereby authorize payment to be made directly to Life Force Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Life Force Chiropractic for any and all services I receive at this office.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Completed

\_\_\_\_\_  
Life Force Representative Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Form Reviewed

## LIFE FORCE CHIROPRACTIC PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception area. Once you have read this notice, please sign the last page, and return to our front desk receptionist. Keep this page for your records.

### PERMITTED DISCLOSURES:

1. Treatment purposes – discussion with other health care providers in your care.
2. Inadvertent disclosures – open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes – to obtain payment from your insurance company or any other collateral source.
4. For workers compensation – to process a claim or aid in investigation.
5. Emergency – in the event of emergency we may notify a family member.
6. For public health and safety – in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government purposes.
9. Deceased persons – discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders – **we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership – in the event this practice is sold the new owners would have access to your PHI.

### YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restriction on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restriction, we are not required to agree with them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). At your request, we will provide you with a copy of your x-rays in our files. **The fee for copying your x-rays on a disc is \$15.00. This fee must be paid in advance.** *(Please note: x-rays are utilized in this office to help locate and analyze vertebral subluxations. These x-rays are not used to investigate for medical pathology. The doctor does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice).*

I have received a copy of Life Force Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

## MEDICAL INFORMATION RELEASE FORM (HIPAA RELEASE)

Name: \_\_\_\_\_

**Release of Information:**

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse \_\_\_\_\_

Child(ren) \_\_\_\_\_

Other \_\_\_\_\_

Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Signed: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_



**CLINICAL EXAM FINDINGS – \*This page for office use only\***

**Subluxation/Palp:**  
 C1  
 C2  
 C3  
 C4  
 C5  
 C6  
 C7  
 T1  
 T2  
 T3  
 T4  
 T5  
 T6  
 T7  
 T8  
 T9  
 T10  
 T11  
 T12  
 L1  
 L2  
 L3  
 L4  
 L5  
 LSI  
 RSI  
 SAC

Cervical	0%	25%	50%	75%	100%	Pain
Flexion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L Lat Flex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R Lat Flex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L Rotation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R Rotation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic	0%	25%	50%	75%	100%	Pain
Flexion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L Rotation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R Rotation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar	0%	25%	50%	75%	100%	Pain
Flexion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L Lat Flex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R Lat Flex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Posture:**  
 FHP + -  
 Head Tilt R L  
 Head Rotation R L  
 High Shoulder R L  
 Thoracic Tilt R L  
 Thoracic Rotation R L  
 High Hip R L  
 Foot Flare R L  
 Short Leg R L

Notes:

\_\_\_\_\_ Doctor/Examiner Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Date