

Date:		Acc.#		Ins. Co.		#of Auth.	Ref.Dr.		
Name:						Age:	DOB		
Subjective	C/C.					ICD	onset		
	1.					ICD	onset		
	2.					ICD	onset		
	3.					ICD	onset		
Objective	BP:	mmHg		H.Rate:	Min.	Bd.Temp:	°F		
	B.WT:	Lbs/Kg		Height:	Ft./mm		BMI: <input type="checkbox"/> Norm <input type="checkbox"/> High <input type="checkbox"/> Over		
Back		(flexion)		Neck		(lateral bending)		(rotation)	
Extension 25° Flexion 90°		Left 25° Right 25°		Extension 60° Flexion 50°		Left 45° Right 45°		Left 80° Right 80°	
Degrees Degrees		Degrees Degrees		Degrees Degrees		Degrees Degrees		Degrees Degrees	
11. Shoulder (Abduction - Adduction)		12. Shoulder (Flexion - Extension)		10. Knee (flexion)		15. Ankle		16. Ankle (Flexion - Extension)	
Left Abduction 150° Adduction 30°		Left Extension 50° Flexion 150°		Left 150° Right 150°		Left Inversion 30° Eversion 20°		Left Plantar 40° Dorsal 20°	
Degrees Degrees		Degrees Degrees		Degrees Degrees		Degrees Degrees		Degrees Degrees	
Right Abduction 150° Adduction 30°		Right Extension 50° Flexion 150°				Right Inversion 30° Eversion 20°		Right Plantar 40° Dorsal 20°	
Degrees Degrees		Degrees Degrees				Degrees Degrees		Degrees Degrees	
17. Wrist (radial, ulnar)		18. Wrist		Pain level		*Before Tx. 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10			
Left Radial 20° Ulnar 30°		Left Extension 60° Flexion 60°				*After Tx. 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10			
Degrees Degrees		Degrees Degrees							
Right Radial 20° Ulnar 30°		Right Extension 60° Flexion 60°		Medications?					
Degrees Degrees		Degrees Degrees		Other Treats?					
Tongue(Bd)		<input type="checkbox"/> Pale <input type="checkbox"/> Pink <input type="checkbox"/> Red <input type="checkbox"/> Dark.Red <input type="checkbox"/> Purpl <input type="checkbox"/> Reddish.Purple <input type="checkbox"/>							
(Coat)		<input type="checkbox"/> White <input type="checkbox"/> Yellw <input type="checkbox"/> Gray <input type="checkbox"/> Blk <input type="checkbox"/> Thin <input type="checkbox"/> Thick <input type="checkbox"/> Dry <input type="checkbox"/> Slipp <input type="checkbox"/> Wet <input type="checkbox"/> Greasy <input type="checkbox"/> Rough <input type="checkbox"/> Sticky <input type="checkbox"/> Graph <input type="checkbox"/> Mirro							
(Shape)		<input type="checkbox"/> Stiff <input type="checkbox"/> Flaccid <input type="checkbox"/> Enlarged <input type="checkbox"/> Short <input type="checkbox"/> Long <input type="checkbox"/> Deviate <input type="checkbox"/> Cracked <input type="checkbox"/> Rolled <input type="checkbox"/> Thin <input type="checkbox"/> Tooth-marked <input type="checkbox"/> Swollen							
Pulse Dx.		<input type="checkbox"/> Superficial부 <input type="checkbox"/> Deep침 <input type="checkbox"/> Slow지 <input type="checkbox"/> Rapid삭 <input type="checkbox"/> Deficient허 <input type="checkbox"/> Excess실 <input type="checkbox"/> Rolling활 <input type="checkbox"/> Tense긴							
(Lt Rt)		<input type="checkbox"/> Thready세 <input type="checkbox"/> String-taut현 <input type="checkbox"/> Hesitant삼 <input type="checkbox"/> Moderate복 <input type="checkbox"/> Surgd홍 <input type="checkbox"/> Abrupt촉 <input type="checkbox"/> Knottd결 <input type="checkbox"/> Intermit.대							
Objective(narration)									
Assessment									
Plans									
		<input type="checkbox"/> 99203(New30m.) <input type="checkbox"/> 99213(Re-Exam.) * <input type="checkbox"/> 97810 <input type="checkbox"/> 97811 Acupuncture * <input type="checkbox"/> 97813 <input type="checkbox"/> 97814 Elect.-Acup <input type="checkbox"/> 98960(Pt. Edu.30m.) <input type="checkbox"/> 97140(Manip.Tx) <input type="checkbox"/> 97010(H/Cold) <input type="checkbox"/> 97016(Cupping) <input type="checkbox"/> 97026(Infra) <input type="checkbox"/> 97039(Moxi) <input type="checkbox"/> _____ <input type="checkbox"/> _____							
Rx.(Acu)		1. Dia.____ Length____ mm.							
Rx.(Herbs)		2.							

Dr's signature _____ Date _____