**S:** Subjective

*Information the patient or patient representative told you*

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| Initials: MJ | | | | | | | Age: 50 | | | | | | Gender: M | |
| Height | Weight | BP | | HR | RR | Temp | | SPO2 | | Pain | Allergies | | | |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. | | Choose an item. | Medication: Denies  Food: Denies  Environment: Denies | | | |
| **History of Present Illness (HPI)** | | | | | | | | | | | | | | |
| **Chief Complaint (CC)** | | | Lower back pain | | | | | | | | | | | *CC is a BRIEF statement identifying why the patient is here - in the patient’s own words - for instance "headache", NOT "bad headache for 3 days”. Sometimes a patient has more than one complaint. For example: If the patient presents with cough and sore throat, identify which is the CC and which may be an associated symptom* |
| ***O***nset | | | 3 days ago following heavy lifting | | | | | | | | | | |
| ***L***ocation | | | Lower back especially left side | | | | | | | | | | |
| ***D***uration | | | Intermittent to “constant for hours” | | | | | | | | | | |
| ***C***haracteristics | | | Sharp and pinching pain. Rates 3-7/10 on pain scale; 6/10 while sitting. Radiates to side of left leg into side of left foot. | | | | | | | | | | |
| ***A***ggravating *Factors* | | | Standing, walking, lifting, and sitting for longer than 15 minutes | | | | | | | | | | |
| ***R****elieving Factors* | | | Temporary relief with lying on back with knees bent; Also bending forward slightly with hands on knees for support | | | | | | | | | | |
| ***T***reatment | | | Ibuprofen “doesn’t seem to help much” | | | | | | | | | | |
| **Current Medications:** *Include dosage, frequency, length of time used and reason for use; also include OTC or homeopathic products.* | | | | | | | | | | | | | | |
| **Medication**  *(Rx, OTC, or Homeopathic)* | | | | | **Dosage** | | | | **Frequency** | | | **Length of Time Used** | | **Reason for Use** |
| Ibuprofen | | | | | Unknown | | | | As needed | | | Unknown | | Back pain |
| Multivitamin | | | | | Unknown | | | | Daily | | | Unknown | | General health |
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| **Past Medical History (PMHx) –** *Includes but not limited to immunization status (note date of last tetanus for all adults), past major illnesses, hospitalizations, and surgeries. Depending on the CC, more info may be needed.* | | | | | | | | | | | | | | |
| Denies recent illness, hospitalization, and surgeries. | | | | | | | | | | | | | | |
| **Social History (Soc Hx) -** *Includes but not limited to occupation and major hobbies, family status, tobacco and alcohol use, and any other pertinent data. Include health promotion such as use seat belts all the time or working smoke detectors in the house.* | | | | | | | | | | | | | | |
| Construction worker. Denies use of tobacco products, intravenous, or recreational drugs. Drinks 1-2 bottles of beer per week. Denies regular exercise except for construction work. Lives with wife and 2 sons. | | | | | | | | | | | | | | |
| **Family History (Fam Hx) -** *Includes but not limited to illnesses with possible genetic predisposition, contagious or chronic illnesses. Reason for death of any deceased first degree relatives should be included. Include parents, grandparents, siblings, and children. Include grandchildren if pertinent.* | | | | | | | | | | | | | | |
| Son: Age 3- healthy  Son: Age 9- healthy  Sister: Unknown age- healthy  Mother: 80’s- healthy  Father: 80’s- healthy  Denies general family history of hypertension, cancer, or coronary artery disease | | | | | | | | | | | | | | |

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| **Review of Systems** **(ROS):** *Address all body systems that may help rule in or out a differential diagnosis Check the box next to each positive symptom and provide additional details.* | | | | | | | | | | | | |
| Constitutional | Skin | | | | HEENT | | | | | | | |
| Fatigue Click or tap here to enter text.  Weakness Click or tap here to enter text.  Fever/Chills Click or tap here to enter text.  Weight Gain Click or tap here to enter text.  Weight Loss Click or tap here to enter text.  Trouble Sleeping Click or tap here to enter text.  Night Sweats Click or tap here to enter text.  Other:  Click or tap here to enter text. | Itching Click or tap here to enter text.  Rashes Click or tap here to enter text.  Nail Changes Click or tap here to enter text.  Skin Color Changes Click or tap here to enter text.  Other:  Click or tap here to enter text. | | | | Diplopia Click or tap here to enter text.  Eye Pain Click or tap here to enter text.  Eye redness Click or tap here to enter text.  Vision changes Click or tap here to enter text.  Photophobia Click or tap here to enter text.  Eye discharge Click or tap here to enter text. | | | | Earache Click or tap here to enter text.  Tinnitus Click or tap here to enter text.  Epistaxis Click or tap here to enter text.  Vertigo Click or tap here to enter text.  Hearing Changes Click or tap here to enter text. | | Hoarseness Click or tap here to enter text.  Oral Ulcers Click or tap here to enter text.  Sore Throat Click or tap here to enter text.  Congestion Click or tap here to enter text.  Rhinorrhea Click or tap here to enter text.  Other:  Click or tap here to enter text. | |
| Respiratory | | | Neuro | | | Cardiovascular | | | | | | |
| Cough Click or tap here to enter text.  Hemoptysis Click or tap here to enter text.  Dyspnea Click or tap here to enter text.  Wheezing Click or tap here to enter text.  Pain on Inspiration Click or tap here to enter text.  Sputum Production  Choose an item.  Choose an item.  Choose an item.  Other: Click or tap here to enter text. | | | Syncope or Lightheadedness Click or tap here to enter text.  Headache Click or tap here to enter text.  Numbness Click or tap here to enter text.  Tingling Click or tap here to enter text.  Sensation Changes  Choose an item.  Speech Deficits Click or tap here to enter text.  Other: Click or tap here to enter text. | | | Chest pain Click or tap here to enter text.  SOB Click or tap here to enter text.  Exercise Intolerance Click or tap here to enter text.  Orthopnea Click or tap here to enter text.  Edema Click or tap here to enter text.  Murmurs Click or tap here to enter text. | | | | | | Palpitations Click or tap here to enter text.  Faintness Click or tap here to enter text.  OC Changes Click or tap here to enter text.  Claudications Click or tap here to enter text.  PND Click or tap here to enter text.  Other: Click or tap here to enter text. |
| MSK | | GI | | | | | GU | | | | PSYCH | |
| Pain Click or tap here to enter text.  Stiffness Click or tap here to enter text.  Crepitus Click or tap here to enter text.  Swelling Click or tap here to enter text.  Limited ROM Choose an item.  Redness Click or tap here to enter text.  Misalignment Click or tap here to enter text.  Other: Click or tap here to enter text. | | Nausea/Vomiting Click or tap here to enter text.  Dysphasia Click or tap here to enter text.  Diarrhea Click or tap here to enter text.  Appetite Change Click or tap here to enter text.  Heartburn Click or tap here to enter text.  Blood in Stool Click or tap here to enter text.  Abdominal Pain Click or tap here to enter text.  Excessive Flatus Click or tap here to enter text.  Food Intolerance Click or tap here to enter text.  Rectal Bleeding Click or tap here to enter text.  Other:  Click or tap here to enter text. | | | | | | Urgency Click or tap here to enter text.  Dysuria Click or tap here to enter text.  Burning Click or tap here to enter text.  Hematuria Click or tap here to enter text.  Polyuria Click or tap here to enter text.  Nocturia Click or tap here to enter text.  Incontinence Click or tap here to enter text.  Other: Click or tap here to enter text. | | | Stress Click or tap here to enter text.  Anxiety Click or tap here to enter text.  Depression Click or tap here to enter text.  Suicidal/Homicidal Ideation Click or tap here to enter text.  Memory Deficits Click or tap here to enter text.  Mood Changes Click or tap here to enter text.  Trouble Concentrating Click or tap here to enter text.  Other: Click or tap here to enter text. | |
| GYN | | | | | | | | | | | | |
| Rash Click or tap here to enter text.  Discharge Click or tap here to enter text.  Itching Click or tap here to enter text. | | | | Irregular Menses Click or tap here to enter text.  Dysmenorrhea Click or tap here to enter text.  Foul Odor Click or tap here to enter text. | | | | | | Amenorrhea Click or tap here to enter text.  LMP: Click or tap here to enter text.  Contraception Click or tap here to enter text.  Other:Click or tap here to enter text. | | |

**O:** Objective

*Information gathered during the physical examination by inspection, palpation, auscultation, and palpation. If unable to assess a body system, write “Unable to assess”. Document pertinent positive and negative assessment findings.*

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| **General** | Choose an item.  Click or tap here to enter text. |
| **Skin** | Choose an item.  Click or tap here to enter text. |
| **HEENT** | Choose an item.  Click or tap here to enter text. |
| **Respiratory** | Choose an item.  Click or tap here to enter text. |
| **Neuro** | Choose an item.  Click or tap here to enter text. |
| **Cardiovascular** | Choose an item.  Click or tap here to enter text. |
| **Musculoskeletal** | Choose an item.  Click or tap here to enter text. |
| **Gastrointestinal** | Choose an item.  Click or tap here to enter text. |
| **Genitourinary** | Choose an item.  Click or tap here to enter text. |
| **Psychiatric** | Choose an item.  Click or tap here to enter text. |
| **Gynecological** | Choose an item.  Click or tap here to enter text. |

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| **Problem List** | | |
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| 2 Click or tap here to enter text. | 7 Click or tap here to enter text. | 12 Click or tap here to enter text. |
| 3 Click or tap here to enter text. | 8 Click or tap here to enter text. | 13 Click or tap here to enter text. |
| 4 Click or tap here to enter text. | 9 Click or tap here to enter text. | 14 Click or tap here to enter text. |
| 5 Click or tap here to enter text. | 10 Click or tap here to enter text. | 15 Click or tap here to enter text. |

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| **A: Assessment**  *Medical Diagnoses. Provide 3 differential diagnoses which may provide an etiology for the CC. The first diagnosis (presumptive diagnosis) is the diagnosis with the highest priority. Provide the ICD-10 code and pertinent findings to support each diagnosis.* | | |
| **Differential Diagnosis** | **ICD-10** | **Pertinent positive and negative findings to support your diagnoses from the history and physical** |
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|  |  |  |
| Diagnosis | ICD-10 Code | Pertinent Findings |
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**P: Plan**

*Address all 5 parts of the comprehensive treatment plan. If you do not wish to order an intervention for any part of the treatment plan, write “None at this time” but do not leave any heading blank. No intervention is self-evident. Provide a rationale and evidence-based in-text citation for each intervention.*

|  |  |
| --- | --- |
| **Diagnostics:** *List tests you will order this visit* | |
| Test | Rationale/Citation |
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| **Medications:** *List medications/treatments including OTC drugs you will order and “continue previous meds” if pertinent.* | | | |
| Drug | Dosage | Length of Treatment | Rationale/Citation |
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| **Referral/Consults:** | | | |
| Click or tap here to enter text. | | Rationale/Citation | Click or tap here to enter text. |
| **Education:** | | | |
| Click or tap here to enter text. | | Rationale/Citation | Click or tap here to enter text. |
| **Follow Up:** *Indicate when patient should return to clinic and provide detailed instructions indicating if the patient should return sooner than scheduled or seek attention elsewhere.* | | | |
| Click or tap here to enter text. | | Rationale/Citation | Click or tap here to enter text. |
| **References**  Include at least one evidence-based peer-reviewed journal article which relates to this case. Use the correct APA 6th edition formatting. | | | |
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