U.S. He

PREMIER PERSONNEL RESOURC 151202
DOS: 6/20/13 DOI: 2/22/13 DOB: 3/26/67
Patient: Santillan, Rosario
Case # : 156-238753 Ref # : EMR/ Yb

BTL

…eatment Visit #: 4
…thorized Visit #: 6

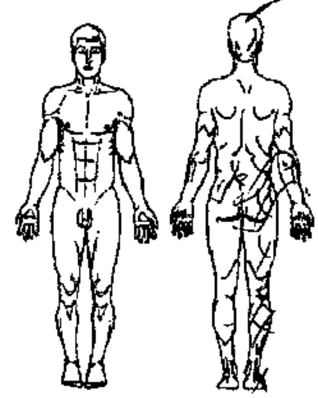
ACUPUNCTURE TREATMENT NOTE

Subjective Pain Level: 0 1 2 3 4 5 6 7 8 9 10 Diagnosis: LR 17

LRP ... radiation to the whole (R) LE (R) LE radiculopathy ...

Objective

(R) PLM
(R) PLM R7L
...



Time **Acupuncture:**

- ☐ Manual Acupuncture: Needles in:__ out:__ Contact Time:___ Needle Time:___
- ☑ Electro-Acupuncture: Needles in: 8 out: 8 Contact Time: 8' Needle Time: 15'
  Needle Points: (R) UB 25 — 40
- ___ ☐ Cupping: ___

Modalities:

- ___ ☐ Vaso-Comp/ Edema Control: ___
- ___ ☐ Electrical Stimulation: ___
- ___ ☐ Hot Pack/ ☐ Cold Pack / ☐ Ice Massage to: ___
- 20' ☑ Infrared Heat: lower back / LE
- ___ ☐ Paraffin Bath: ___
- ___ ☐ Mechanical Traction: ___
- ___ ☐ Other: ___

X= Pain S= Spasm T= Trigger

Rehabilitation:

- 8' ☑ Myofascial Release/Soft Tissue Mobilization PLM / ... / (R) LE
- ___ ☐ Joint Mobs/ Manual Traction: ___
- ___ ☐ FAs/ADLs/KAs/Ind. Instruct: ___
- ___ ☐ Biofeedback: ___
- ___ ☐ Neuromuscular Reeducation: ___
- ___ ☐ Supervised Therapeutic Exercises: (Specify): ___

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet
☐ FCE/Return to Work PAT ☐ PPE (see report) ☐ PePAT (see report)
☐ Other/Supplies: ___
☑ Skin checked and clear following treatment

ASSESSMENT: ☐ Improving functional capacity (Specify below) ☑ Improving with limitations (Specify below)

PLAN: ☑ Progress Acupuncture treatment program (specify below) ☐ Perform PPE / re-evaluation / D/C summary
☐ D/C from Acupuncture: Has met goals / has reached plateau / is non compliant

ARKADIY GALPERIN, LAc
License Number AC9285

Signature: ___ License Number: AC 9285

ST 6515 (8/12)

U.S. Health MEDICAL

PREMIER PERSONNEL RESOURC 151202
DOS: 7/01/13 DOI: 2/22/13 DOB: 3/26/67
Patient: Santillan, Rosario
Case # : 156-238753 Ref # : EMR/ Yb

BIL

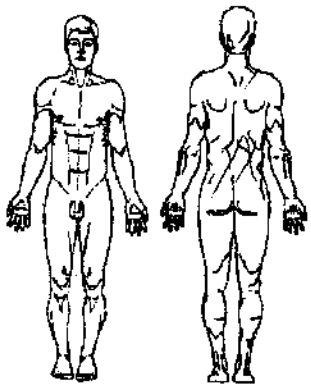
nent Visit #: 6
Authorized Visit #: 6

UNCTURE TREATMENT NOTE

Subjective Pain Level: 0 1 2 3 4 5 6 7 8 9 10 Diagnosis: LBP @ L5 radicular sx/pain to leg

Objective

@ PVM



X= Pain S= Spasm T= Trigger

Time **Acupuncture:**

- ☑ Manual Acupuncture: Needles in: 2 out: 2 Contact Time: 7 Needle Time: 15'
- ☑ Electro-Acupuncture: Needles in: 2 out: 2 Contact Time: 8 Needle Time: 15'
  Needle Points: GB 15 / SI
- ☐ Cupping:

Modalities:

- ☐ Vaso-Comp/ Edema Control:
- ☐ Electrical Stimulation:
- ☐ Hot Pack/ ☐ Cold Pack / ☐ Ice Massage to:
- 20' ☑ Infrared Heat: heat
- ☐ Paraffin Bath:
- ☐ Mechanical Traction:
- ☐ Other:

Rehabilitation:

- 8' ☑ Myofascial Release/Soft Tissue Mobilization PVM
- ☐ Joint Mobs/ Manual Traction:
- ☐ FAs/ADLs/KAs/Ind. Instruct:
- 10' ☑ Biofeedback: PVM - Scalenes / neck
- ☐ Neuromuscular Reeducation:
- ☐ Supervisod Therapeutic Exercises: (Specify):

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet
☐ FCE/Return to Work PAT ☐ PPE (see report) ☐ PePAT (see report)
☐ Other/Supplies:
☑ Skin checked and clear following treatment

ASSESSMENT: ☐ Improving functional capacity (Specify below) ☑ Improving with limitations (Specify below)
Pain, spasm, tenderness

PLAN: ☑ Progress Acupuncture treatment program (specify below) ☐ Perform PPE / re-evaluation / D/C summary
☐ D/C from Acupuncture: Has met goals / has reached plateau / is non compliant

Signature: ARKADIY GALPERIN, LAc License Number: AC9285

ST 6515 (8/12)

ARKADIY GALPERIN, LAc
License Number AC9285

PREMIER PERSONNEL RESOURC 151202
DOS: 6/27/13 DOI: 2/22/13 DOB: 3/26/67
Patient: Santillan, Rosario
Case # : 156-238753 Ref # : EMR/ Yb

BIL

Treatment Visit #: 5
Authorized Visit #: 6

DAILY ACUPUNCTURE TREATMENT NOTE

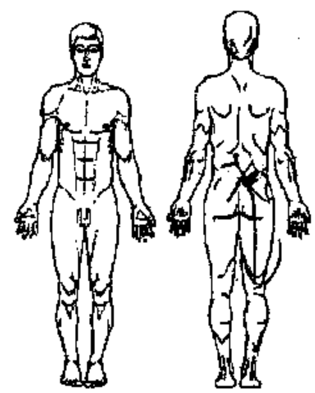
Subjective Pain Level: 0 1 2 3 4 5 6 7 8 9 10 (6 circled)

Diagnosis: [illegible]

[illegible handwriting]

Objective

[illegible handwriting]



Time **Acupuncture:**

- ☐ Manual Acupuncture: Needles in:___ out:___ Contact Time:___ Needle Time:___
- ☑ Electro-Acupuncture: Needles in: 7 out: 7 Contact Time: 10 Needle Time: 10
- Needle Points: [illegible]
- ___ ☐ Cupping: ______

Modalities:

- ___ ☐ Vaso-Comp/ Edema Control: ______
- ___ ☐ Electrical Stimulation: ______
- ___ ☐ Hot Pack/ ☐ Cold Pack / ☐ Ice Massage to: ______
- 10 ☑ Infrared Heat: L/S
- ___ ☐ Paraffin Bath: ______
- ___ ☐ Mechanical Traction: ______
- ___ ☐ Other: ______

X= Pain S= Spasm T= Trigger

Rehabilitation:

- ___ ☐ Myofascial Release/Soft Tissue Mobilization ______
- 10 ☑ Joint Mobs/ Manual Traction: ext
- ___ ☐ FAs/ADLs/KAs/Ind. Instruct: ______
- ___ ☐ Biofeedback: ______
- ___ ☐ Neuromuscular Reeducation: ______
- ___ ☐ Supervised Therapeutic Exercises: (Specify): ______

☑ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet
☐ FCE/Return to Work PAT ☐ PPE (see report) ☐ PePAT (see report)
☐ Other/Supplies: ______
☐ Skin checked and clear following treatment

ASSESSMENT: ☑ Improving functional capacity (Specify below) ☑ Improving with limitations (Specify below)

PLAN: ☑ Progress Acupuncture treatment program (specify below) ☐ Perform PPE / re-evaluation / D/C summary
☐ D/C from Acupuncture: Has met goals / has reached plateau / is non compliant

Signature: [signature]

License Number: AC 13010

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ST 6515 (8/12)

PREMIER PERSONNEL RESOURC 151202
DOS: 6/17/13 DOI: 2/22/13 DOB: 3/26/67
Patient: Santillan, Rosario
Case # : 156-238753 Ref # : EMR/ Yb

BIL

Treatment Visit #: 7
Authorized Visit #: 6

DAILY ACUPUNCTURE TREATMENT NOTE

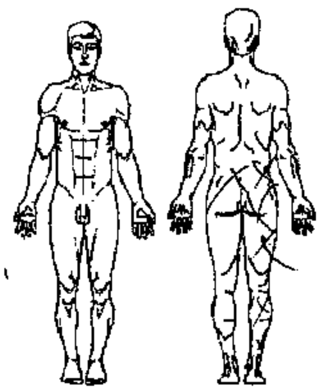
Subjective Pain Level: 0 1 2 3 4 5 (6) 7 8 9 10

Diagnosis: LBP
(R) Lt radiculitis/ inflammatory

Objective

(-) ROM

(+) (R) tenderness



X= Pain S= Spasm T= Trigger

Time **Acupuncture:**

- ☐ Manual Acupuncture: Needles in:___ out:___ Contact Time:___ Needle Time:___
- ☑ Electro-Acupuncture: Needles in: 2 out: 2 Contact Time: 8 Needle Time: 15
- Needle Points: (R) UB 25 - Ashi
- ☐ Cupping: ___

Modalities:

- ☐ Vaso-Comp/ Edema Control: ___
- ☐ Electrical Stimulation: ___
- ☐ Hot Pack/ ☐ Cold Pack / ☐ Ice Massage to: ___
- 8' ☑ Infrared Heat: lumbar ___ / 15
- ☐ Paraffin Bath: ___
- ☐ Mechanical Traction: ___
- ☐ Other: ___

Rehabilitation:

- 8' ☑ Myofascial Release/Soft Tissue Mobilization ROM/ ___
- ☐ Joint Mobs/ Manual Traction: ___
- ☐ FAs/ADLs/KAs/Ind. Instruct: ___
- ☐ Biofeedback: ___
- ☐ Neuromuscular Reeducation: ___
- ☐ Supervised Therapeutic Exercises: (Specify): ___

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet
☐ FCE/Return to Work PAT ☐ PPE (see report) ☐ PePAT (see report)
☐ Other/Supplies: ___
☑ Skin checked and clear following treatment

ASSESSMENT: ☐ Improving functional capacity (Specify below) ☑ Improving with limitations (Specify below)

PLAN: ☑ Progress Acupuncture treatment program (specify below) ☐ Perform PPE / re-evaluation / D/C summary
☐ D/C from Acupuncture: Has met goals / has reached plateau / is non compliant

ARKADIY GALPERIN, LAc
License Number AC9285

Signature: ___ License Number: AC 9285

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ST 6515 (8/12)

U.S. H PREMIER PERSONNEL RESOURC 151202
DOS: 6/13/13 DOI: 2/22/13 DOB: 3/26/67
Patient: Santillan, Rosario
Case # : 156-238753 Ref # : EMR/ Yb

BIL

Treatment Visit #: 2
Authorized Visit #: 6

ACUPUNCTURE TREATMENT NOTE

Subjective Pain Level: 0 1 2 3 4 5 6 (7) 8 9 10

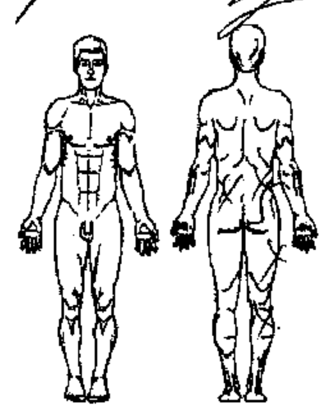
Diagnosis: LBP
(R) LE radicular symptomatology

LBP 7/10 (R) leg

Objective

(E) PLM

(R) along the course of (R) sciatic n.



Time	
	Acupuncture:
	☐ Manual Acupuncture: Needles in:__ out:__ Contact Time:__ Needle Time:__
	☑ Electro-Acupuncture: Needles in: 2 out: 2 Contact Time: 2 Needle Time: 15
	Needle Points: (R) UB 27 - Ashi p.
	☐ Cupping:
	Modalities:
	☐ Vaso-Comp/ Edema Control:
	☐ Electrical Stimulation:
	☐ Hot Pack/ ☐ Cold Pack / ☐ Ice Massage to:
22'	☑ Infrared Heat: lower back
	☐ Paraffin Bath:
	☐ Mechanical Traction:
	☐ Other:
	Rehabilitation:
8'	☑ Myofascial Release/Soft Tissue Mobilization PLM
	☐ Joint Mobs/ Manual Traction:
	☐ FAs/ADLs/KAs/Ind. Instruct:
	☐ Biofeedback:
	☐ Neuromuscular Reeducation:
	☐ Supervised Therapeutic Exercises: (Specify):

X= Pain S= Spasm T= Trigger

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet
☐ FCE/Return to Work PAT ☐ PPE (see report) ☐ PePAT (see report)
☐ Other/Supplies:
☑ Skin checked and clear following treatment

ASSESSMENT: ☐ Improving functional capacity (Specify below) ☑ Improving with limitations (Specify below)

PLAN: ☑ Progress Acupuncture treatment program (specify below) ☐ Perform PPE / re-evaluation / D/C summary
☐ D/C from Acupuncture: Has met goals / has reached plateau / is non compliant

ARKADIY GALPERIN, LAc
License Number AC9225

Signature: [signature] License Number: AC 9225

PREMIER PERSONNEL RESOURC 151202
DOS: 6/10/13 DOI: 2/22/13 DOB: 3/26/67
Patient: Santillan, Rosario
Case # : 156-238753 Ref # : EMR/ Yb

BJL

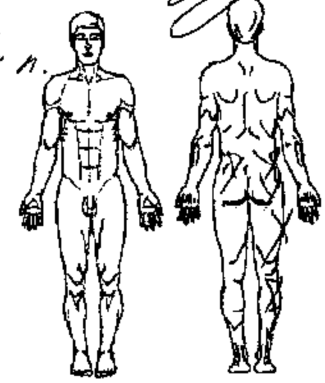
...ment Visit #: 1
...orized Visit #: 6

...LY ACUPUNCTURE TREATMENT NOTE

Subjective Pain Level: 0 1 2 3 4 5 6 (7 8) 9 10
LBP → (R) leg

Diagnosis: LBP
(R) LE radicular symptoms

Objective
(+) PLM
(+) along the course of sciatic n.



Time **Acupuncture:**

☐ Manual Acupuncture: Needles in:__ out:__ Contact Time:__ Needle Time:__
☑ Electro-Acupuncture: Needles in: 2 out: 2 Contact Time: 8' Needle Time: 15'
Needle Points: (R) UB 25-27
☐ Cupping:

Modalities:
☐ Vaso-Comp/ Edema Control:
15' ☑ Electrical Stimulation: PLM
☐ Hot Pack/ ☐ Cold Pack / ☐ Ice Massage to:
20' ☑ Infrared Heat: lower back / LE
☐ Paraffin Bath:
☐ Mechanical Traction:
☐ Other:

X= Pain S= Spasm T= Trigger

Rehabilitation:
8' ☑ Myofascial Release/Soft Tissue Mobilization: PLM / (R) gluteal piriformis m. group
☐ Joint Mobs/ Manual Traction:
☐ FAs/ADLs/KAs/Ind. Instruct:
☐ Biofeedback:
☐ Neuromuscular Reeducation:
10' ☑ Supervised Therapeutic Exercises: (Specify): PIR ē stretching PLM

☑ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet
☐ FCE/Return to Work PAT ☐ PPE (see report) ☐ PePAT (see report)
☐ Other/Supplies:
☑ Skin checked and clear following treatment

ASSESSMENT: ☐ Improving functional capacity (Specify below) ☐ Improving with limitations (Specify below)

PLAN: ☑ Progress Acupuncture treatment program (specify below) ☐ Perform PPE / re-evaluation / D/C summary
☐ D/C from Acupuncture: Has met goals / has reached plateau / is non compliant

Signature: [signature] License Number: AC 9285

US HealthWorks MEDICAL GROUP

ACUPUNCTURE WORKSHEET

☐ New Patient ☐ Established Patient

MA / NURSE NOTES. Dominant hand: ☐ Right ☐ Left Allergies: ____

Medications: ____ Problems/Side effects: ____

☐ Yes ☐ No History of ulcers or gastritis? ☐ Yes ☐ No Possibly pregnant?

Occupational History:

Job Title: ____ Length of employment with company: ____ yrs Average hours per week: ____

Main Job Characteristics At The Time Of Injury:

☐ Sit down job ☐ Prolonged standing or walking ☐ Repetitive use of hands/ keyboard/ mouse ☐ Kneeling or squatting

☐ Bending ☐ Stooping ☐ Climbing ☐ Overhead work ☐ Operating hand tools / Machinery

☐ Lifting / Pulling / Pushing ☐ Up to 10 lbs. ☐ Up to 25 lbs. ☐ Up to 50 lbs. ☐ Up to ____ lbs. Other ____

☐ Yes ☐ No Any lost work time? If Yes, specify number of full days lost: ____ and last date worked ____

☐ Yes ☐ No Any other source of employment? If Yes, specify: ____

☐ Yes ☐ No Any sports or hobbies? If Yes, specify: ____

☐ Yes ☐ No Any previous treatment for the complaint(s) before coming to U.S. HealthWorks? If Yes, specify: ____

Chief Complaint: LBP

Ht: ____ in Wt: ____ lbs Pulse: 72 /min BP: ____ mmHg Resp: 18 /min Temp: ____ °F

Completed by: ____

PHYSICIAN HISTORY (Explain any Yes answers below)

☐ Yes ☑ No Chemical / toxic exposure involved?

☐ Yes ☑ No Any previous occupational injuries or illnesses?

☐ Yes ☑ No Any pre-existing condition that could complicate or prolong the patient's diagnosis, treatment, and/or rate of recovery?

History of Present Illness/Injury: (Describe below the mechanism of injury, progression of illness, and the characteristics of the chief complaint)

The patient was treated for her LBP ē improvement but still c/o (R) radiated to (R) LE, as well as stiffness lower back exacerbated by [illegible]

Chief Complaint #1: LBP

Location: ____

Quality: ☐ Faint ☐ Sharp ☐ Dull ☐ Tingling ☐ Burning

Severity: ☐ Minimal ☑ Mild ☑ Moderate ☐ Severe

Duration: ____ Min ____ Hours ✓ ____ Days

Timing: ☐ Occasional ☑ Intermittent ☑ Constant

Context: ____

Modifying Factors: Exacerbated by: [illegible]

Lessened by: rest

Chief Complaint #2: Pain

Location: (R) LE

Quality: ☐ Faint ☑ Sharp ☐ Dull ☐ Tingling ☐ Burning

Severity: ☐ Minimal ☑ Mild ☑ Moderate ☐ Severe

Duration: ✓ Min ✓ Hours ____ Days

Timing: ☐ Occasional ☑ Intermittent ☐ Constant

Context: ____

Modifying Factors: Exacerbated by: [illegible]

Lessened by: rest

Relevant History. Comments:

☑ As part of my evaluation, I reviewed the information above, as well as the patient's **Medical, Family and Social History** and the **Review of Systems** collected today.

Provider Signature

PREMIER PERSONNEL RESOURC 151202
DOS: 6/10/13 DOI: 2/22/13 DOB: 3/26/67
Patient: Santillan, Rosario
Case # : 156-238753 Ref # : EMR/ Yb

DOCUMENTATION ABOVE.

ACUPUNCTURE WORKSHEET

nt #: ____ Date: ____

U.S. HealthWorks MEDICAL GROUP

ACUPUNCTURE SPINE

Associated Symptoms ☐ None (Check all that apply.)

☐ Yes ☐ No Fatigue ☐ Yes ☐ No Fever ☐ Yes ☐ No Arm/Neck Pain ☑ Yes ☐ No Lumbar/Flank Pain
☐ Yes ☐ No Paresthesias ☐ Yes ☐ No Weakness ☐ Yes ☐ No Changes in bowel habits ☐ Yes ☐ No Bowel/Bladder dysfunction?
☐ Yes ☐ No Other: *Sciatica*

EXAM: (Check all the statements that apply and **explain any Yes answers** below. If not all items in a statement are positive; check and explain those that apply.)

1. ☐ Yes ☑ No **Disoriented** to time, place and person and/or **non-alert**?
2. ☐ Yes ☑ No **Mood and affect** appear **inappropriate**?
3. ☐ Yes ☐ No Abnormal **posture or gait**?

Neck

4. ☐ Yes ☑ No Loss of **cervical lordosis**?
5. ☐ Yes ☑ No ☐ **Erythema**, ☐ **ecchymosis**, ☐ **scars**, ☐ **masses**, ☐ **swelling**, or ☐ **deformities** in neck?
6. ☐ Yes ☐ No ☐ Neck **stiffness** or ☐ **splinting**?
7. ☐ Yes ☑ No ☐ **Posterior cervical tenderness**?
8. ☐ Yes ☑ No ☐ **Tenderness** or ☐ **muscle spasms** in the ☐ Paracervical ☐ Sternocleidomastoid ☐ Trapezius muscles?
9. ☐ Yes ☑ No ☐ Abnormal **thyroid palpation**?
10. ☐ Yes ☑ No **Restricted range of motion of the neck?** (If Yes, specify restrictions below.)
    Flex: ____/45° Ext: ____/55° Lat Flexion: R___/L___/40° Lat. Rotation: R___/L___/70°
11. ☐ Yes ☑ No **Weakness of the upper extremity muscles?** (If Yes, grade the weakness below.)
    Shoulder abduction (C5) R:___/L:___/5 Wrist extension (C6) R:___/L:___/5 Wrist flexion (C7) R:___/L:___/5
    Finger extension (C7) R:___/L:___/5 Finger Flexion (C8) R:___/L:___/5 Shoulder adduction (T1) R:___/L:___/5

Back

12. ☐ Yes ☑ No ☐ **Erythema**, ☐ **ecchymosis**, ☐ **scars**, ☐ **masses**, ☐ **swelling** or ☐ **deformities** of the **thoracolumbar region**?
13. ☐ Yes ☑ No ☐ **Kyphosis** or ☐ **scoliosis**?
14. ☑ Yes ☐ No ☑ **Tenderness** or ☐ **spasm** of the ☐ thoracolumbar spine or the ☑ paravertebral musculature?
15. ☐ Yes ☑ No ☐ **Costovertebral angle tenderness** for renal involvement?
16. ☐ Yes ☑ No **Restricted range of motion** of the back? (If Yes, specify restrictions below.)
    Flexion: Fingertips to: ☐ Mid-Thigh ☐ Knee ☐ Mid-tibia ☐ Ankles ☐ ______ inches from floor
    Ext. ______/30° Lat. Flexion R:___/L:___/45° Lat. Rotation R:___/L:___/30°
17. ☐ Yes ☑ No **Weakness** of the lower extremities? (If Yes, grade the weakness below.)
    Hip Flex (T12-L3) R:___/L:___/5 Foot Dorsiflex-inv (L4) R:___/L:___/5 Great Toe Dorsiflex (L5) R:___/L:___/5
18. ☑ Pos ☑ Neg **Straight Leg Raise Test** for sciatic nerve involvement. Right: + at *90* degrees. Left: + at ____ degrees.
19. ☐ Pos ☐ Neg **Patrick-Fabere Test** for pathology of sacroiliac joint. 20. ☐ Pos ☐ Neg **Wadell's Signs** for symptom magnification.

Neurovascular

21. ☐ Yes ☑ No **Abnormal deep tendon reflexes in LE?** (If Yes, grade response.) Patellar (L2, L3, L4) R:___/L:___/2 Achilles Tendon (S1 R:___/L:___/2
22. ☑ Yes ~~☑ No~~ **Any sensory changes to light touch** and **pinprick**? (If Yes, specify area of decreased sensation below.)
    R / L Medial Forearm (T1) R / L Medial Arm (T2) R / L Torso (T2-T7)
    R / L Anterior Thigh (L1-L3) R / L Medial Leg/Foot (L4) R / L Lateral Leg/Medial Foot (L5)
    (R) / L Lateral Leg/Dorsal Foot (L5) R / L Lateral Ventral Foot (S1) R / L Thoracoabdominal region
23. ☐ Yes ☐ No **Abnormal pulses or capillary refill in LE?** ______
24. ☐ Yes ☑ No **Abnormal deep tendon reflexes in UE?** (If Yes, grade the response below.)
    Bicipital (C5) R:___/L:___/2 Brachioradialis (C6) R:___/L:___/2 Tricipital (C7) R:___/L:___/2
25. ☐ Yes ☑ No **Any sensory changes to light touch** and **pinprick in upper extremities**? (If Yes, specify area of decreased sensation below.)
    R / L Lat. arm sensation (C5) R / L Lat. forearm sensation (C6) R / L Middle finger sensation (C7)
    R / L Medial forearm sensation (C8) R / L Medial arm sensation (T1)
26. ☐ Yes ☑ No **Abnormal pulses or capillary refill** in UE? ______
27. ☐ Yes ☑ No **Signs** of apparent **dependent lymphedema**?

General

28. ☐ Yes ☑ No ☐ **Erythema**, ☐ **abrasions**, ☐ **ecchymosis**, ☐ **rash**?
29. ☐ Yes ☑ No Abnormal **abdominal palpation**?
30. ☐ Yes ☑ No Costovertebral angle tenderness for **Renal involvement**?

Explanation of abnormalities and other physical findings:

(+) PVM
(+) along the course of (R) sciatic n.
(+) SLR test (R) 90°
(+) (R) pirif.-glut. m. p.

IF I | PREMIER PERSONNEL RESOURC 151202
DOS: 6/10/13 DOI: 2/22/13 DOB: 3/26/67
Name Patient: Santillan, Rosario
Case # : 156-238753 Ref # : EMR/ Yb

...CUMENTATION ABOVE.

ACUPUNCTURE SPINE

Date: ______

ST651.

US HealthWorks MEDICAL GROUP

ACUPUNCTURE LOWER EXTREMITY

Associated Symptoms ☐ None (Check all that apply.)
☐ Yes ☐ No Urinary ☐ Urgency ☐ Frequency ☐ Dysuria ☐ Hematuria ☐ Nocturia ☐ Polyuria ☐ Fever, chills? ☐ Yes ☐ No Bowel/Bladder dysfunction?
☐ Yes ☐ No Paresthesias ☐ Yes ☐ No Weakness ☐ Yes ☐ No Changes in bowel habits ☐ Yes ☐ No Pain radiation to: ______

EXAM: (Check all the statements that apply and **explain any Yes answers** below. If not all items in a statement are positive; check and explain those that apply.)

☑ **Right** ☐ **Left** **Contralateral**

1. ☐ Yes ☑ No **Disoriented** to time, place and person and/or **non-alert**?
2. ☐ Yes ☑ No **Mood and affect appear inappropriate?**
3. ☐ Yes ☑ No Abnormal **posture or gait?**

Hip / Thigh

4. ☐ Yes ☑ No ☐ Yes ☐ No ☐ **Erythema,** ☐ **ecchymosis,** ☐ **scars,** ☐ **masses,** or ☐ **swelling,** or ☐ **deformities** in the hip or thigh?
5. ☑ Yes ☐ No ☐ Yes ☐ No ☑ **Tenderness** or ☐ **spasm** musculature of the ☑ buttock or ☑ thigh?
6. ☐ Yes ☐ No ☐ Yes ☐ No ☐ **Tenderness** or ☐ **deformity** of the ☐ **Greater** or ☐ **Lesser Trochanter?**
7. ☐ Yes ☑ No ☐ **Restricted range of motion** of the hip? (If Yes, specify restrictions below.)
   Flexion: R___/L___/135° Extension: R___/L___/30° Abduction R___/L___/45°
   Adduction R___/L___/20° Int. Rotation R___/L___/35° Ext. Rotation R___/L___/45°
8. ☑ Pos ☐ Neg **Straight Leg Raise Test** for sciatic nerve involvement. Right: + at 90 degrees. Left: + at ____ degrees.
9. ☐ Pos ☐ Neg **Anvil Test** for hip or leg pathology.
10. ☐ Pos ☐ Neg **Patrick-Fabere Test** for pathology of sacroiliac joint.

Knees

11. ☐ Yes ☐ No ☐ Yes ☐ No ☐ **Erythema,** ☐ **ecchymosis,** ☐ **scars,** ☐ **masses,** ☐ **swelling** or ☐ **deformities** in the **knees?**
12. ☐ Yes ☐ No ☐ Yes ☐ No ☐ **Tenderness** of the ☐ **medial and lateral knee joint lines?**
13. ☐ Yes ☐ No ☐ Yes ☐ No ☐ **Patellar subluxation** or ☐ **tenderness?**
14. ☐ Yes ☐ No ☐ Yes ☐ No ☐ **Knee joint effusion** present?
15. ☐ Yes ☐ No **Restrictions to the range of motion?** (If Yes, specify restrictions below.)
    Extension: R___/L___/0° Flexion: R___/L___/135° Int. Rotation: R___/L___/10° Ext. Rotation: R___/L___/10°
16. ☐ Pos ☑ Neg **Abduction/Adduction Stress Tests** for integrity of coll. lig.
17. ☐ Pos ☐ Neg **McMurray Test** for meniscal tears.
18. ☐ Pos ☐ Neg **Bulge Sign / Ballottement Test** for joint effusion.
19. ☐ Pos ☐ Neg **Ant. Post / Drawer Sign** for integrity of cruciate ligament.
20. ☐ Pos ☑ Neg **Apprehension** Test for patellar dislocation or subluxation.
21. ☐ Pos ☐ Neg **Patello-Femoral Grinding Test** for retropatellar pathology.

Ankle / Feet

22. ☐ Yes ☑ No ☐ Yes ☐ No ☐ **Erythema,** ☐ **ecchymosis,** ☐ **scars,** ☐ **swelling,** ☐ **masses,** or ☐ **deformities** in feet or ankles?
23. ☐ Yes ☑ No ☐ Yes ☐ No ☐ Points of **tenderness** in feet or ankles?
24. ☐ Yes ☐ No **Restrictions to the ankle's range of motion?** (If Yes, specify restrictions below.)
    Dorsiflex: R___/L___/20° Plantar Flex: R___/L___/50° Inversion: R___/L___/30° Eversion: R___/L___/20°
25. ☐ Yes ☐ No **Restrictions to the Great Toe's range of motion?** (If Yes, specify restrictions.) MT: R___/L___ IP: R___/L___
26. ☐ Yes ☐ No **Restrictions to the Lesser Toes' range of motion?** (If Yes, specify restrictions.) Toes#______ MT: R___/L___ IP: R___/L___
27. ☐ Yes ☐ No **Muscle weakness?** (If Yes, grade any weakness.) Dorsiflexion: R___/L___/5 Plantar Flexion: R___/L___/5
28. ☐ Pos ☐ Neg **Eversion Stress Test** for medial instability of ankle.
29. ☐ Pos ☐ Neg **Inversion Stress Test** for lateral instability of ankle.
30. ☐ Pos ☐ Neg **Anterior Drawer Sign** for instability of the ankle joint.
31. ☐ Pos ☐ Neg **Thompson Squeeze Test** for Achilles tendon integrity.

Neurovascular

32. ☐ Yes ☐ No **Abnormal deep tendon reflexes in LE?** (If Yes, grade response.) Patellar (L2, L3, L4) R___/L___/2 Achilles Tendon (S1) R___/L___/2
33. ☑ Yes ☐ No **Any sensory changes to light touch and pinprick** in lower extremities? (If Yes, specify area of decreased sensation below.)
    R / L Anterior Thigh (L1-L3) R / L Medial Leg/Foot (L4) R / L Lateral Leg/Medial Foot (L5)
    (R) / L Lateral Leg/Dorsal Foot (L5) R / L Lateral Ventral Foot (S1) R / L Thoracoabdominal region
34. ☐ Yes ☑ No **Abnormal pulses in LE?** (If Yes, grade the intensity.) Femoral R:___ L:___/4 Popliteal R:___ L:___/4 Post. Tibial R:___ L:___/4
35. ☐ Yes ☑ No ☐ Yes ☐ No ☐ **Signs of apparent dependent lymphedema** or ☐ **inguino-crural lymphadenopathy?**
35. ☐ Yes ☐ No ☐ **Signs of apparent respiratory distress** (tachypnea, hyperpnea, etc.)?

Explanation of abnormalities and other physical findings:

(+) along the course of (R) sciatic n.
↓ sensation (R) L5
(+) SLR test 90° (R)

PREMIER PERSONNEL RESOURC 151202
DOS: 6/10/13 DOI: 2/22/13 DOB: 3/26/67
Patient: Santillan, Rosario
Case # : 156-238753 Ref # : EMR/ Yb

Name:

UMENTATION ABOVE.

ACUPUNCTURE LOWER EXTREMITY

Date:______

U.S. HealthWorks MEDICAL GROUP

DIAGNOSES: (Specify all diagnoses by numbering in order of importance.)

Lower back pain
Right LE radiculopathy
#
#
#

ADDITIONAL COMMENTS:

TREATMENT PLAN:

☐ **Acupuncture Treatment:** 2 times/week for 3 weeks

Procedures:
- ☑ Acupuncture
- ☑ Electro-Acupuncture
- ☑ Myofascial Release
- ☐ Joint Mobilization
- ☐ Neuro Muscular Re-Ed
- ☐ SEMG Biofeedback
- ☐ Cupping
- ☐ Individualized Instruction

Exercise Therapy:
- ☐ Postural education/exercise
- ☐ Strengthening
- ☑ Stretching
- ☐ Stabilization
- ☐ A/AA/PROm
- ☐ Swiss Ball
- ☐ Home exercise Program
- ☐ Body Mechanics/Jt. protection

Modalities:
- ☑ Electrical Stimulation
- ☑ Infrared Heat
- ☐ Hot/Cold Pack
- ☐ Vasopneumatic compression
- ☐ Traction
- ☐ Paraffin Bath

Other: Specify:

Supplies ☐ **The following medical supplies were dispensed and the patient instructed in their proper use:**

☐ Cold Pack ☐ Hot Pack ☐ Lumbar Support ☐ Lumbar Pillow ☐ Foam Roller ☐ Exercise Booklet
☐ Stabilizer ☐ Swiss Ball ☐ Cervical Roll ☐ Theracane ☐ Theraband ☐ Theraputty
☐ Other: ☐ Other:
☐ Other: ☐ Other:

Other:

☐ **Interpreter used** ☐ **Certified interpreter unavailable.** Name:

Work Status: ☐ Regular work ☐ Modified work ☐ Off work. Explain:

☐ **Counseling visit:** Total duration of visit: ____ mins. Total duration of patient counseling: ____ mins.

Return to clinic on:

☐ **Discharged from care.** No further treatment is anticipated at this center at this time.

CONSULT / REFERRAL:

☐ **Patient advised to follow up with personal physician for non-work-related condition.**
Specify:

☐ Suggestion for **Consult / Referral to Specialist** to be discussed with Primary Treating Physician.

☐ Suggestion for **Consult / Referral to PT/OT/Chiro** to be discussed with Primary Treating Physician.
Reasons:

LABELS

ARKADIY GALPERIN, LAc.
License Number AC9285

PATIENT EDUCATION:

Patient voiced understanding of:
- ☑ **possible temporary increase in symptoms, following initial Acupuncture treatment**
- ☐ **aftercare instructions and expected progression of the injury**
- ☐ **advised to call US HealthWorks if unexpected symptoms appear after treatment**

EMPLOYER CONTACT: ☐ **Discussed case /** ☐ **Left detailed message with:** on the issues of:

☐ Causation ☐ Diagnoses ☐ Prognosis ☐ Work Status Other:

ARKADIY GALPERIN, LAc.
License Number AC9285

ACUPUNCTURIST Signature: Name:

PREMIER PERSONNEL RESOURC 151202
DOS: 6/10/13 DOI: 2/22/13 DOB: 3/26/67
Patient: Santillan, Rosario
Case # : 156-238753 Ref # : EMR/ Yb

DOCUMENTATION ABOVE.

t #: Date:

U.S. HealthWorks MEDICAL GROUP

DAILY THERAPY TREATML... BIL

Treatment Visit #: 6
Authorized Visits #: 6

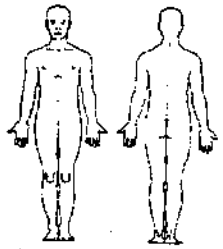
PREMIER PERSONNEL RESOURC 151202
DOS: 5/13/13 DOI: 2/22/13 DOB: 3/26/67
Patient: Santillan, Rosario
Case # : 156-238753 Ref # : EMR/ Yb

Auth Exp Date: _____

Diagnosis:
R L B lumbar s/s

Subjective: O Improved O Same O Worsened Pain level 0 1 2 3 4 5 6 7 8 9 10 O See attached Report

Objective: (i.e. ROM, MMT, Posture, Girth, Color) O See attached report
O Evaluation: O Re-evaluation O Strength/ROM O Progress Report O FCE/Return to Work PAT
O Isokinetics _____ minutes : O Custom Splint/Orthotic O Sensory Eval O Burn/Wound Care



Time	Modalities: (circle body parts) O Right O Left O Both
___	O Vaso-comp/Edema Control: Neck Shlder Arm Elbow Forearm Wrist/Hand/Finger/Thumb T/S L/S Hip Thigh Knee Leg Ankle/Foot
15	● Electrical Stimulation: Neck Shlder Arm Elbow Forearm Wrist/Hand/Finger/Thumb T/S L/S Hip Groin Thigh Knee Leg Ankle/Foot
	● IFC O TENS O H-Wave O EMS O Micro O Pre-mod O HV O LV 50-150 lb
___	O Hot/Cold Pack/Ice Massage to: Neck Shoulder Arm Elbow Forearm Wrist/Hand T/S L/S Hip Groin Thigh Knee Leg Ankle/Foot
15	● Infrared Heat Neck Shoulder Arm Elbow Forearm Wrist/Hand T/S L/S Hip Thigh Knee Leg Ankle/Foot
~~15~~	● Infrared/Light Probe: _____ J/ cm² Area: _____
___	O Whirlpool/Fluido (_____ °F) to Arm Elbow Forearm Wrist/Hand Hip Thigh Knee Leg Ankle/Foot Other:
___	O Paraffin Bath Elbow Forearm Wrist/Hand Ankle/Foot
15	● Mechanical Traction O Cervical ● Lumbosacral O Carpal Tunnel C-Trac O Static: _____ lbs/mmhg
	● Intermit: Hold 60 lbs/mmhg 30 sec/min Relax 40 lbs 10 sec/min
___	O Ultrasound/Phonophoresis - Cont. or Pulsed _____% @ _____w / cm² _____MHz to _____(area)
___	O Iontophoresis (ml of Dexamethasone HCPCS: J1100 B.C.: 5052 Item# 226395) at _____(milliamp-min)
	Rehabilitation: Area: _____ O in clinic O Extended wear: _____hours
10	● Myofascial Release/Soft Tissue Mobilization LS
___	O Joint Mob/Manual Traction: Grade: I II III IV V: Body part: _____
___	O Orthotic/Splinting Training/Taping _____ O Applied/Fitted/Instructed
___	O FAs/ADLs/KAs/ _____
___	O Indiv Instruct O HEP O Injury Education O DME/TENS Instruct O Edema Control O Krames book HCPCS: 99071 BC: 6860
___	O Biofeedback: O Facilitate O Inhibit Muscle location/Action: _____ Hld: ___s Rst: ___s Reps: ___
	Threshold: _____µV Output: _____µV O Triode Electrode dispensed: HCPCS: A4556 BC: 3186 Item# 922301
___	O Neuromuscular Re-education _____
___	O Gait Training/Assistive Device Training O Cane O Crutches O Walker _____
20	● Supervised Therapeutic Exercises: by: ●PT O PTA O OT O **Aquatic Therapy** Initial 30 min O ea additional 15 min
___	● See Exercise Flow Sheet (in chart) _____
___	_____

O Established/Reviewed/Progressed Home Program O See Handout/Booklet _____
O Supplies: issued to facilitate HEP and/or supplement supervised clinic program _____
● **Skin checked and clear following treatment**

Assessment: (specify below) O Improved functional capacity O Improving with limitations O See attached Report
pt tolerated tx

O Treatment Plan Reviewed by Supervising Therapist O Physical Therapist of Record Transfer on file

Plan: O progress therapeutic treatment program (specify below) O perform Re-Eval / MMT&ROM/DC summary
O D/C from therapy: Has met goals / has reached plateau / is non-compliant O See attached Report
Completed auth visits, will need new auth to continue therapy

MARIA LOPEZ, PT, DPT

CA4105 (REV. 11/12) Signature _____ License Number PT 19314

Maciej Majzel, D.C., Chiropractic Corporation.

Acupuncture [ ]Initial [✓]Follow Up Evaluation

Account # 7343
Date of Injury: 05/1/12 - 4/8/14
Date of Examination: 7/7/16

Patient's Name: Santillan, Manu Gender: ☐ M ☑ F DOB: 3/26/67 SSN: _____
Dominant Hand: ☑ R ☐ L

Referring Physician: Vlad Gendelman Contra Indications _____

History: The patient sustained ☑ Industrial ☐ Personal Injury(ies) to _____

The patient was evaluated by Dr. Gendelman and referred to Acupuncturist for evaluation and treatment as necessary.

PTP Diagnosis: 1. C/S 7. _____
2. L/S 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

Subjective Complaints

☐ Head					
☐ Pain	☐ no	☐ if yes	☐ slight	☐ moderate	☐ severe
☐ Numbness	☐ no	☐ yes			
☐ Nausea	☐ no	☐ yes			
☑ C-Spine					
☐ Pain	☐ no	☑ if yes	☐ slight	☐ moderate	☑ severe
☐ Strength	☐ normal	☐ decreased			
☐ Numbness	☐ no	☐ yes	8/10		
☐ Decreased ROM	☐ no	☐ yes			
☑ Spasm	☐ no	☑ yes			
☐ T-Spine					
☐ Pain	☐ no	☐ if yes	☐ slight	☐ moderate	☐ severe
☐ Strength	☐ normal	☐ decreased			
☐ Numbness	☐ no	☐ yes			
☐ Decreased ROM	☐ no	☐ yes			
☐ Spasm	☐ no	☐ yes			
☑ L-Spine					
☐ Pain	☐ no	☑ if yes	☐ slight	☐ moderate	☑ severe
☐ Strength	☐ normal	☐ decreased			
☐ Numbness	☐ no	☑ yes	8/10		
☐ Decreased ROM	☐ no	☑ yes			
☑ Spasm	☐ no	☑ yes			
☐ Chest/Abdomen					
☐ Pain	☐ no	☐ if yes	☐ slight	☐ moderate	☐ severe
☐ Strength	☐ normal	☐ decreased			
☐ Numbness	☐ no	☐ yes			

☐ R Shoulder					
☐ Pain	☐ no	☐ if yes	☐ slight	☐ moderate	☐ severe
☐ Strength	☐ normal	☐ decreased			
☐ Numbness	☐ no	☐ yes			
☐ Decreased ROM	☐ no	☐ yes			
☐ R Arm					
☐ Pain	☐ no	☐ if yes	☐ slight	☐ moderate	☐ severe
☐ Strength	☐ normal	☐ decreased			
☐ Numbness	☐ no	☐ yes			
☐ R Elbow					
☐ Pain	☐ no	☐ if yes	☐ slight	☐ moderate	☐ severe
☐ Strength	☐ normal	☐ decreased			
☐ Numbness	☐ no	☐ yes			
☐ Decreased ROM	☐ no	☐ yes			
☐ R Forearm					
☐ Pain	☐ no	☐ if yes	☐ slight	☐ moderate	☐ severe
☐ Strength	☐ normal	☐ decreased			
☐ Numbness	☐ no	☐ yes			
☐ R Wrist					
☐ Pain	☐ no	☐ if yes	☐ slight	☐ moderate	☐ severe
☐ Strength	☐ normal	☐ decreased			
☐ Numbness	☐ no	☐ yes			
☐ Decreased ROM	☐ no	☐ yes			
☐ R Hand					
☐ Pain	☐ no	☐ if yes	☐ slight	☐ moderate	☐ severe
☐ Strength	☐ normal	☐ decreased			
☐ Numbness	☐ no	☐ yes			
☐ Decreased ROM	☐ no	☐ yes			
☐ R Hip					
☐ Pain	☐ no	☐ if yes	☐ slight	☐ moderate	☐ severe
☐ Strength	☐ normal	☐ decreased			
☐ Numbness	☐ no	☐ ye			
☐ Decreased ROM	☐ no	☐ yess			
☐ R Thigh					
☐ Pain	☐ no	☐ if yes	☐ slight	☐ moderate	☐ severe
☐ Strength	☐ normal	☐ decreased			
☐ Numbness	☐ no	☐ yes			
☐ R Knee					
☐ Pain	☐ no	☐ if yes	☐ slight	☐ moderate	☐ severe
☐ Strength	☐ normal	☐ decreased			
☐ Numbness	☐ no	☐ yes			
☐ Decreased ROM	☐ no	☐ yes			
☐ R Lower Leg					
☐ Pain	☐ no	☐ if yes	☐ slight	☐ moderate	☐ severe
☐ Strength	☐ normal	☐ decreased			
☐ Numbness	☐ no	☐ yes			
☐ R Ankle					
☐ Pain	☐ no	☐ if yes	☐ slight	☐ moderate	☐ severe
☐ Strength	☐ normal	☐ decreased			
☐ Numbness	☐ no	☐ yes			
☐ Decreased ROM	☐ no	☐ yes			

☐ R Foot
- ☐ Pain ☐ no ☐ if yes ☐ slight ☐ moderate ☐ severe
- ☐ Strength ☐ normal ☐ decreased
- ☐ Numbness ☐ no ☐ yes
- ☐ Decreased ROM ☐ no ☐ yes

☐ L Shoulder
- ☐ Pain ☐ no ☐ if yes ☐ slight ☐ moderate ☐ severe
- ☐ Strength ☐ normal ☐ decreased
- ☐ Numbness ☐ no ☐ yes
- ☐ Decreased ROM ☐ no ☐ yes

☐ L Arm
- ☐ Pain ☐ no ☐ if yes ☐ slight ☐ moderate ☐ severe
- ☐ Strength ☐ normal ☐ decreased
- ☐ Numbness ☐ no ☐ yes

☐ L Elbow
- ☐ Pain ☐ no ☐ if yes ☐ slight ☐ moderate ☐ severe
- ☐ Strength ☐ normal ☐ decreased
- ☐ Numbness ☐ no ☐ yes
- ☐ Decreased ROM ☐ no ☐ yes

☐ L Forearm
- ☐ Pain ☐ no ☐ if yes ☐ slight ☐ moderate ☐ severe
- ☐ Strength ☐ normal ☐ decreased
- ☐ Numbness ☐ no ☐ yes

☐ L Wrist
- ☐ Pain ☐ no ☐ if yes ☐ slight ☐ moderate ☐ severe
- ☐ Strength ☐ normal ☐ decreased
- ☐ Numbness ☐ no ☐ yes
- ☐ Decreased ROM ☐ no ☐ yes

☐ L Hand
- ☐ Pain ☐ no ☐ if yes ☐ slight ☐ moderate ☐ severe
- ☐ Strength ☐ normal ☐ decreased
- ☐ Numbness ☐ no ☐ yes
- ☐ Decreased ROM ☐ no ☐ yes

☐ L Hip
- ☐ Pain ☐ no ☐ if yes ☐ slight ☐ moderate ☐ severe
- ☐ Strength ☐ normal ☐ decreased
- ☐ Numbness ☐ no ☐ yes
- ☐ Decreased ROM ☐ no ☐ yes

☐ L Thigh
- ☐ Pain ☐ no ☐ if yes ☐ slight ☐ moderate ☐ severe
- ☐ Strength ☐ normal ☐ decreased
- ☐ Numbness ☐ no ☐ yes

☐ L Knee
- ☐ Pain ☐ no ☐ if yes ☐ slight ☐ moderate ☐ severe
- ☐ Strength ☐ normal ☐ decreased
- ☐ Numbness ☐ no ☐ yes
- ☐ Decreased ROM ☐ no ☐ yes

☐ L Lower Leg
- ☐ Pain ☐ no ☐ if yes ☐ slight ☐ moderate ☐ severe
- ☐ Strength ☐ normal ☐ decreased
- ☐ Numbness ☐ no ☐ yes

☐ L Ankle

☐ Pain	☐ no	☐ if yes	☐ slight	☐ moderate	☐ severe
☐ Strength	☐ normal	☐ decreased			
☐ Numbness	☐ no	☐ yes			
☐ Decreased ROM	☐ no	☐ yes			
☐ L Foot					
☐ Pain	☐ no	☐ if yes	☐ slight	☐ moderate	☐ severe
☐ Strength	☐ normal	☐ decreased			
☐ Numbness	☐ no	☐ yes			
☐ Decreased ROM	☐ no	☐ yes			
☐ _____					
☐ Pain	☐ no	☐ if yes	☐ slight	☐ moderate	☐ severe
☐ Strength	☐ normal	☐ decreased			
☐ Numbness	☐ no	☐ yes			

Medical History

☐ Diabetes	☐ Hypertension	☐ Cancer	☐ Epilepsy	☐ Arthritis	☐ Coronary Artery Disease
☐ Pregnant	☐ Hepatitis	☐ Skin Irritation	☐ Heart Disease	☐ Lung Disease	☐ Kidney Disease
☐ Meningitis	☐ Unremarkable	☐ _____	☐ _____	☐ _____	☐ _____

Surgical History

☐ Pacemaker	☐ Post Surgery	☐ Metal Implant	☐ Abdomnal/R/L Inguinal Herniorrhaphy	☐ R/L Rotator Cuff Repair	☐ Spinal Surgery
☐ Elbow Surgery	☐ Knee Surgery	☐ Wrist Surgery	☐ Appendectomy	☐ Unremarkable	☐ _____

Observation

Pulse	☐ Superficial	☐ Deep	☐ Rapid	☐ Slippery	
	☐ Choppy	☐ Thin	☐ Soft	☑ Wiry	
Tongue Appearance	☐ Pale	☐ Red	☐ Dark red	☐ Purple	☐ Blue
	☐ Wet	☐ Dry	☐ Red Spots	☐ Swollen	☐ Teeth Marks
	☐ White Coating	☑ Yellow Coating	☐ No Coating	☐ Cracked	

Patient's Name _____

Progress Summary

Body Part 1 C/S

	Last Visit	Today	
Pain	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 (8) 9 10	☐ No change
Spasm	0 1 1+ 2 3 4	0 1 1+ 2 3 (4)	☐ No change
Tenderness	0 1 2 3 4	0 1 2 (3)	☐ No change
Relaxation	10 20 30 40 50 60 70 80 90 100 %	Improvement since last visit	☐ No change
ROM	10 20 30 40 50 60 70 80 90 100 %	Improvement since last visit	☐ No change
Nausea	10 20 30 40 50 60 70 80 90 100 %	Improvement since last visit	☐ No change
Blood Flow	10 20 30 40 50 60 70 80 90 100 %	Improvement since last visit	☐ No change
Swelling	10 20 30 40 50 60 70 80 90 100 %	Improvement since last visit	☐ No change
Sensitivity	10 20 30 40 50 60 70 80 90 100 %	Improvement since last visit	☐ No change
Numbness	10 20 30 40 50 60 70 80 90 100 %	Improvement since last visit	☐ No change
Inflammation	10 20 30 40 50 60 70 80 90 100 %	Improvement since last visit	☐ No change

Body Part 2 L/S

Pain	0 1 2 3 4 5 6 7 (8) 9 10	0 1 2 3 4 5 6 7 (8) 9 10	☐ No change
Spasm	0 1 1+ 2 3 (4)	0 1 1+ 2 3 (4)	☐ No change
Tenderness	0 1 2 3 (4)	0 1 2 3 (4)	☐ No change
Relaxation	10 (20) 30 40 50 60 70 80 90 100 %	Improvement since last visit	☐ No change
ROM	10 20 (30) 40 50 60 70 80 90 100 %	Improvement since last visit	☐ No change
Nausea	10 20 30 40 50 60 70 80 90 100 %	Improvement since last visit	☐ No change
Blood Flow	10 20 30 40 50 60 70 80 90 100 %	Improvement since last visit	☐ No change
Swelling	10 20 30 40 50 60 70 80 90 100 %	Improvement since last visit	☐ No change
Sensitivity	10 20 30 40 (50) 60 70 80 90 100 %	Improvement since last visit	☐ No change
Numbness	10 20 30 40 50 60 70 80 90 100 %	Improvement since last visit	☐ No change
Inflammation	10 20 30 40 50 60 70 80 90 100 %	Improvement since last visit	☐ No change

Patient's Name _____ Acc. # _____

TCM Diagnostics

☐ Qi and blood stagnation in the channel(s):

☐ LU - Lung	☐ LI - Large Intestine	☐ ST - Stomach	☐ SP - Spleen
☐ HT - Heart	☐ SI - Small Intestine	☑ UB - Urinary Bladder	☐ KD - Kidney
☐ PC - Pericardium	☑ SJ - San Jiao	☑ GB - Gall Bladder	☐ LIV - Liver
☐ REN - Conception Vessel	☐ DU - Governing Vessel		

☐ Other _____

Progress Summary

☐ No benefits yet	☑ Continues to improve
☐ Temporary pain relief	☐ Reached maximum benefits
☐ Unable to tolerate acupuncture	

Treatment Goals

☑ Reduce Pain	☑ Reduce Tenderness	☑ Increase ROM	☐ Decrease Sensitivity
☑ Reduce Muscle Spasm	☑ Decrease Numbness	☑ Decrease Swelling	☐ Promote Relaxation
	☐ Reduce Nausea	☐ Reduce Inflammation	☐ Increase Blood Flow

Recommendation

☑ Schedule 3 times a week for 4 weeks. ☐ Consult with PTP _____

Treatment Plan

☐ Acupuncture to the following points: ☐ Electroacupuncture to the following points:

LU	LI	ST	SP	HT	SI	UB	KD	PC	SJ	GB	LIV	REN	DU
1 ☐	1 ☐	1 ☐	1 ☐	1 ☐	1 ☐	1 ☐	1 ☐	1 ☐	1 ☐	1 ☐	1 ☐	1 ☐	1 ☐
2 ☐	2 ☐	2 ☐	2 ☐	2 ☐	2 ☐	2 ☐	2 ☐	2 ☐	2 ☐	2 ☐	2 ☐	2 ☐	2 ☐
3 ☐	3 ☐	3 ☐	3 ☐	3 ☐	3 ☐	3 ☐	3 ☐	3 ☐	3 ☐	3 ☐	3 ☐	3 ☐	3 ☐
4 ☐	4 ☐	4 ☐	4 ☐	4 ☐	4 ☐	4 ☐	4 ☐	4 ☐	4 ☐	4 ☐	4 ☐	4 ☐	4 ☐
5 ☐	5 ☐	5 ☐	5 ☐	5 ☐	5 ☐	5 ☐	5 ☐	5 ☐	5 ☐	5 ☐	5 ☐	5 ☐	5 ☐
6 ☐	6 ☐	6 ☐	6 ☐	6 ☐	6 ☐	6 ☐	6 ☐	6 ☐	6 ☐	6 ☐	6 ☐	6 ☐	6 ☐
7 ☐	7 ☐	7 ☐	7 ☐	7 ☐	7 ☐	7 ☐	7 ☐	7 ☐	7 ☐	7 ☐	7 ☐	7 ☐	7 ☐
8 ☐	8 ☐	8 ☐	8 ☐	8 ☐	8 ☐	8 ☐	8 ☐	8 ☐	8 ☐	8 ☐	8 ☐	8 ☐	8 ☐
9 ☐	9 ☐	9 ☐	9 ☐	9 ☐	9 ☐	9 ☐	9 ☐	9 ☐	9 ☐	9 ☐	9 ☐	9 ☐	9 ☐
10 ☐	10 ☐	10 ☐	10 ☐		10 ☐	10 ☐	10 ☐		10 ☐	10 ☐	10 ☐	10 ☐	10 ☐
11 ☐	11 ☐	11 ☐	11 ☐		11 ☐	11 ☐	11 ☐		11 ☐	11 ☐	11 ☐	11 ☐	11 ☐
12 ☐	12 ☐	12 ☐	12 ☐		12 ☐	12 ☐	12 ☐		12 ☐	12 ☐	12 ☐	12 ☐	12 ☐

Patient's Name _____ Acc. # _____

LU	LI	ST	SP	HT	SI	UB	KD	PC	SJ	GB	LIV	REN	DU
	13 ☐	13 ☐	13 ☐		13 ☐	13 ☐	13 ☐		13 ☐	13 ☐	13 ☐	13 ☐	13 ☐
	14 ☐	14 ☐	14 ☐		14 ☐	14 ☐	14 ☐		14 ☐	14 ☐	14 ☐	14 ☐	14 ☐
	15 ☐	15 ☐	15 ☐		15 ☐	15 ☐	15 ☐		15 ☐	15 ☐		15 ☐	15 ☐
	16 ☐	16 ☐	16 ☐		16 ☐	16 ☐	16 ☐		16 ☐	16 ☐		16 ☐	16 ☐
	17 ☐	17 ☐	17 ☐		17 ☐	17 ☐	17 ☐		17 ☐	17 ☐		17 ☐	17 ☐
	18 ☐	18 ☐	18 ☐		18 ☐	18 ☐	18 ☐		18 ☐	18 ☐		18 ☐	18 ☐
	19 ☐	19 ☐	19 ☐		19 ☐	19 ☐	19 ☐		19 ☐	19 ☑		19 ☐	19 ☐
	20 ☐	20 ☐	20 ☐			20 ☐	20 ☐		20 ☐	20 ☑		20 ☐	20 ☐
		21 ☐	21 ☐			21 ☐	21 ☐		21 ☐	21 ☑		21 ☐	21 ☐
		22 ☐				22 ☐	22 ☐		22 ☐	22 ☑		22 ☐	22 ☐
		23 ☐				23 ☐	23 ☐		23 ☐	23 ☐		23 ☐	23 ☐
		24 ☐				24 ☑	24 ☐			24 ☐		24 ☐	24 ☐
		25 ☐				25 ☑	25 ☐			25 ☐			25 ☐
		26 ☐				26 ☑	26 ☐			26 ☐			26 ☐
		27 ☐				27 ☑	27 ☐			27 ☐			27 ☐
		28 ☐				28 ☑				28 ☐			28 ☐
		29 ☐				29 ☑				29 ☐			
		30 ☐				30 ☑				30 ☐			
		31 ☐				31 ☑				31 ☐			
		32 ☐				32 ☐				32 ☐			
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		45 ☐				45 ☐							
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						49 ☐							

LU	LI	ST	SP	HT	SI	UB	KD	PC	SJ	GB	LIV	REN	DU
						50 ☐ 51 ☐ 52 ☐ 53 ☐ 54 ☐ 55 ☐ 56 ☐ 57 ☐ 58 ☐ 59 ☐ 60 ☐ 61 ☐ 62 ☐ 63 ☐ 64 ☐ 65 ☐ 66 ☐ 67 ☐								

☐ Anmian	☐ Bizhong	☐ Huatuojiaji	☐ Pigen	☐ Sishencong	☐ Yiming
☑ Ashi points	☐ Dannangxue	☐ Jiachengjiang	☐ Qianzheng	☐ Taiyang	☑ Yintang
☐ Bafeng	☐ Dingchuan	☐ Ianqian	☐ Qiuhou	☐ Weiguanxiashu	☐ Yuyao
☐ Baichongwo	☐ Erbai	☐ Jinjin, Yuye	☐ Shanglianquan	☐ Xiyan	☐ Zhongkui
☐ Bailao	☐ Erjian	☐ Lanweixue	☐ Shiqizhui	☐ Yaoqi	☐ Zhongquan
☐ Baxie	☐ Heding	☐ Luozhen	☐ Shixuan	☐ Yaotongxue	☐ Zhoujian
☐ Bitong	☐ Huanzhong		☐ Sifeng	☐ Yaoyan	☐ Zigongxue

☐ Acupressure	☐ Auriculotherapy	☐ Cupping	☐ Herbal Treatment
☐ Hot Pack	☐ Cold Pack	☑ Infrared	☐ Myofascial Release
☐ Therapeutic Exercise	☐ Tuina Massage	☐ _____	☐ _____

Acupuncturist Name Young Tae Kim L. Ac. **Signature** _____

License # AC9394

☑ **Visit was performed with the aid of a Qualified Interpreter**

Name of Interpreter Lucia Contreras **Company** Accurate Interpreting

Interpreter Signature _____

Patient Signature _____

Acupuncture Treatment

Patient's Name Sintillan, Maria Acct.# 7343

Acupuncture Notes/Codes

Subjective Complaints: Body Part -1 C/S

Pain	[ ] not improved	[X] slightly improved	[ ] Improved	[ ] worsened
Spasm	[ ] not improved	[X] slightly improved	[ ] Improved	[ ] worsened
Tenderness	[X] not improved	[ ] slightly improved	[ ] Improved	[ ] worsened
ROM	[ ] not improved	[X] slightly improved	[ ] Improved	[ ] worsened
Swelling	[ ] not improved	[X] slightly improved	[ ] Improved	[ ] worsened

Objective Findings: [ ] Pain [ ] Spasm [ ] Tenderness [ ] Swelling [ ] Redness

[ ] Reduced [ ] No change

Subjective Complaints: Body Part -2 U/S

Pain	[ ] not improved	[X] slightly improved	[ ] Improved	[ ] worsened
Spasm	[X] not improved	[ ] slightly improved	[ ] Improved	[ ] worsened
Tenderness	[X] not improved	[ ] slightly improved	[ ] Improved	[ ] worsened
ROM	[ ] not improved	[X] slightly improved	[ ] Improved	[ ] worsened
Swelling	[ ] not improved	[X] slightly improved	[ ] Improved	[ ] worsened

Objective Findings: [ ] Pain [X] Spasm [X] Tenderness [ ] Swelling [ ] Redness

[ ] Reduced [ ] No change

Assessment/Comments: [ ] No benefits yet [ ] Temporary relief of symptoms [X] Continues to improv

Treatment Plan: [X] Continue Current Treatment [ ] Terminate Current Treatment

[ ] Reached Max. Benefits

[X] Visit was performed with the aid of a Qualified Interpreter

Name of Interpreter Lidia Centeno Company. Accurate Interpreting, Inc. Signature:

Acupuncturist: Young Tae Kim, L. Ac. License No. AC 9394 Signature:

Visit # 10 Follow up Patient's Signature Date 7/07/16

6200 Wilshire Blvd. Suite 910 Los Angeles, CA 90048 Phone: 323-934-0423 Fax: 323-934-4762

PREMIER PERSONNEL RESOURC 151202
DOS: 6/10/13 DOI: 2/22/13 DOB: 3/26/67
Patient: Santillan, Rosario
Case # : 156-238753 Ref # : EMR/ Yb

BIL

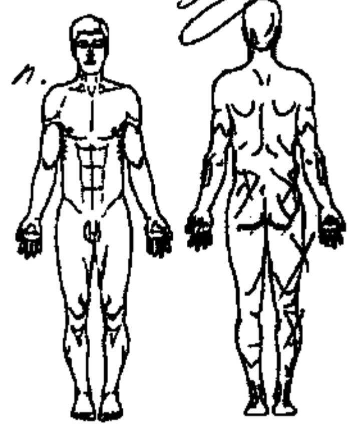
ment Visit #: 1
orized Visit #: 6

LY ACUPUNCTURE TREATMENT NOTE

Subjective Pain Level: 0 1 2 3 4 5 6 (7 8) 9 10
LBP → ↓ R leg

Diagnosis: LBP
R LE radicular
symptomatology

Objective
(+) PCM
(+) along the course of sciatic n.



X= Pain S= Spasm T= Trigger

Time **Acupuncture:**
- ☐ Manual Acupuncture: Needles in:__ out:__ Contact Time:__ Needle Time:__
- ☑ Electro-Acupuncture: Needles in: 2 out: 2 Contact Time: 8' Needle Time: 15'
  Needle Points: R UB 25-27
- __ ☐ Cupping:

Modalities:
- __ ☐ Vaso-Comp/ Edema Control:
- 15' ☑ Electrical Stimulation: PCM
- __ ☐ Hot Pack/ ☐ Cold Pack / ☐ Ice Massage to:
- 20' ☑ Infrared Heat: lower back/hip
- __ ☐ Paraffin Bath:
- __ ☐ Mechanical Traction:
- __ ☐ Other:

Rehabilitation:
- 8' ☑ Myofascial Release/Soft Tissue Mobilization: PCM / R Glut - Piriformis
- __ ☐ Joint Mobs/ Manual Traction:
- __ ☐ FAs/ADLs/KAs/Ind. Instruct:
- __ ☐ Biofeedback:
- __ ☐ Neuromuscular Reeducation:
- 10' ☑ Supervised Therapeutic Exercises: (Specify): PIR c stretching PCM

☑ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet
☐ FCE/Return to Work PAT ☐ PPE (see report) ☐ PePAT (see report)
☐ Other/Supplies:
☑ Skin checked and clear following treatment

ASSESSMENT: ☐ Improving functional capacity (Specify below) ☐ Improving with limitations (Specify below)

PLAN: ☑ Progress Acupuncture treatment program (specify below) ☐ Perform PPE / re-evaluation / D/C summary
☐ D/C from Acupuncture: Has met goals / has reached plateau / is non compliant

Signature: [signature] License Number: AC 9285

ST 6515 (8/12)

US HealthWorks MEDICAL GROUP

ACUPUNCTURE WORKSHEET

☐ New Patient ☐ Established Patient

MA / NURSE NOTES. Dominant hand: ☐ Right ☐ Left Allergies: ____________

Medications: ____________ Problems/Side effects: ____________

☐ Yes ☐ No History of ulcers or gastritis? ☐ Yes ☐ No Possibly pregnant?

Occupational History:

Job Title: ____________ Length of employment with company: ______ yrs Average hours per week: ______

Main Job Characteristics At The Time Of Injury:

☐ Sit down job ☐ Prolonged standing or walking ☐ Repetitive use of hands/ keyboard/ mouse ☐ Kneeling or squatting

☐ Bending ☐ Stooping ☐ Climbing ☐ Overhead work ☐ Operating hand tools / Machinery

☐ Lifting / Pulling / Pushing ☐ Up to 10 lbs. ☐ Up to 25 lbs. ☐ Up to 50 lbs. ☐ Up to ______ lbs. Other ____________

☐ Yes ☐ No Any lost work time? If Yes, specify number of full days lost: ______ and last date worked ______

☐ Yes ☐ No Any other source of employment? If Yes, specify: ____________

☐ Yes ☐ No Any sports or hobbies? If Yes, specify: ____________

☐ Yes ☐ No Any previous treatment for the complaint(s) before coming to U.S. HealthWorks? If Yes, specify: ____________

Chief Complaint: LBP

Ht: ______ in Wt: ______ lbs Pulse: 72 /min BP: ______ mmHg Resp: 18 /min Temp: ______ °F

Completed by: ____________

PHYSICIAN HISTORY (Explain any Yes answers below)

☐ Yes ☑ No Chemical / toxic exposure involved?

☐ Yes ☑ No Any previous occupational injuries or illnesses?

☐ Yes ☑ No Any pre-existing condition that could complicate or prolong the patient's diagnosis, treatment, and/or rate of recovery?

History of Present Illness/Injury: (Describe below the mechanism of injury, progression of illness, and the characteristics of the chief complaint)

The patient was treated for her LBP c̄ improvement but still c/o [illegible] radiated to Ⓡ LE, as well as stiffness. Lower back exacerbated by motion.

Chief Complaint #1: LBP	**Chief Complaint #2:** pain
Location:	**Location:** Ⓡ LE
Quality: ☐ Faint ☐ Sharp ☑ Dull ☐ Tingling ☐ Burning	**Quality:** ☐ Faint ☑ Sharp ☑ Dull ☐ Tingling ☐ Burning
Severity: ☐ Minimal ☑ Mild ☑ Moderate ☐ Severe	**Severity:** ☐ Minimal ☑ Mild ☑ Moderate ☐ Severe
Duration: ____ Min ____ Hours ____ Days	**Duration:** ✓ Min ✓ Hours ____ Days
Timing: ☐ Occasional ☑ Intermittent ☑ Constant	**Timing:** ☐ Occasional ☑ Intermittent ☐ Constant
Context:	**Context:**
Modifying Factors: Exacerbated by: walking	**Modifying Factors:** Exacerbated by: walking
Lessened by: rest	Lessened by: rest

Relevant History. Comments:

☑ As part of my evaluation, I reviewed the information above, as well as the patient's **Medical, Family and Social History** and the **Review of Systems** collected today.

Provider Signature

PREMIER PERSONNEL RESOURC 151202
DOS: 6/10/13 DOI: 2/22/13 DOB: 3/26/67
Patient: Santillan, Rosario
454-238753 Ref #: EMR/ Yb

DOCUMENTATION ABOVE.

ACUPUNCTURE WORKSHEET

nt #: ____________ Date: ____________

US HealthWorks MEDICAL GROUP

ACUPUNCTURE SPINE

Associated Symptoms ☐ None (Check all that apply.)

☐ Yes ☐ No Fatigue ☐ Yes ☐ No Fever ☐ Yes ☐ No Arm/Neck Pain ☑ Yes ☐ No Lumbar/Flank Pain
☐ Yes ☐ No Paresthesias ☐ Yes ☐ No Weakness ☐ Yes ☐ No Changes in bowel habits ☐ Yes ☐ No Bowel/Bladder dysfunction?
☐ Yes ☐ No Other: Pt. denies

EXAM: (Check all the statements that apply and explain any **Yes answers** below. If not all items in a statement are positive; check and explain those that apply.)

1. ☐ Yes ☑ No **Disoriented** to time, place and person and/or **non-alert**?
2. ☐ Yes ☑ No **Mood and affect** appear **inappropriate**?
3. ☐ Yes ☐ No Abnormal **posture or gait**?

Neck

4. ☐ Yes ☑ No Loss of **cervical lordosis**?
5. ☐ Yes ☑ No ☐ **Erythema**, ☐ **ecchymosis**, ☐ **scars**, ☐ **masses**, ☐ **swelling**, or ☐ **deformities** in neck?
6. ☐ Yes ☐ No ☐ Neck **stiffness** or ☐ **splitting**?
7. ☐ Yes ☐ No ☐ **Posterior cervical tenderness**?
8. ☐ Yes ☐ No ☐ **Tenderness** or ☐ **muscle spasms** in the ☐ Paracervical ☐ Sternocleidomastoid ☐ Trapezius muscles?
9. ☐ Yes ☐ No ☐ Abnormal **thyroid palpation**?
10. ☐ Yes ☐ No **Restricted range of motion of the neck?** (If Yes, specify restrictions below.)
    Flex ____/45° Ext: ____/55° Lat Flexion: R____/L____/40° Lat. Rotation: R____/L____/70°
11. ☐ Yes ☑ No **Weakness of the upper extremity muscles?** (If Yes, grade the weakness below.)
    Shoulder abduction (C5) R:____/L:____/5 Wrist extension (C6) R:____/L:____/5 Wrist flexion (C7) R:____/L:____/5
    Finger extension (C7) R:____/L:____/5 Finger Flexion (C8) R:____/L:____/5 Shoulder adduction (T1) R:____/L:____/5

Back

12. ☐ Yes ☑ No ☐ **Erythema**, ☐ **ecchymosis**, ☐ **scars**, ☐ **masses**, ☐ **swelling** or ☐ **deformities** of the **thoracolumbar region**?
13. ☐ Yes ☑ No ☐ **Kyphosis** or ☐ **scoliosis**?
14. ☑ Yes ☐ No ☑ **Tenderness** or ☐ **spasm** of the ☐ thoracolumbar spine or the ☑ paravertebral musculature?
15. ☐ Yes ☑ No ☐ **Costovertebral angle tenderness** for renal involvement?
16. ☐ Yes ☑ No **Restricted range of motion** of the back? (If Yes, specify restrictions below.)
    Flexion: Fingertips to: ☐ Mid-Thigh ☐ Knee ☐ Mid-tibia ☐ Ankles ☐ _____ inches from floor
    Ext._____/30° Lat. Flexion R:____/L:____/45° Lat. Rotation R:____/L:____/30°
17. ☐ Yes ☑ No **Weakness** of the lower extremities? (If Yes, grade the weakness below.)
    Hip Flex (T12-L3) R:____/L:____/5 Foot Dorsiflex-Inv (L4) R:____/L:____/5 Great Toe Dorsiflex (L5) R:____/L:____/5
18. ☑ Pos ☑ Neg **Straight Leg Raise Test** for sciatic nerve involvement. Right: + at 90 degrees. Left: + at _____ degrees.
19. ☑ Pos ☐ Neg **Patrick-Fabere Test** for pathology of sacroiliac joint. 20. ☐ Pos ☐ Neg **Wadell's Signs** for symptom magnification.

Neurovascular

21. ☐ Yes ☑ No **Abnormal deep tendon reflexes in LE?** (If Yes, grade response.) Patellar (L2, L3, L4) R:____/L:____/2 Achilles Tendon (S1 R:____/L:____/2
22. ☑ Yes ☐ No **Any sensory changes** to **light touch** and **pinprick**? (If Yes, specify area of decreased sensation below.)
    R / L Medial Forearm (T1) R / L Medial Arm (T2) R / L Torso (T2-T7)
    R / L Anterior Thigh (L1-L3) R / L Medial Leg/Foot (L4) R / L Lateral Leg/Medial Foot (L5)
    R / L Lateral Leg/Dorsal Foot (L5) R / L Lateral Ventral Foot (S1) R / L Thoracoabdominal region
23. ☐ Yes ☐ No **Abnormal pulses or capillary refill** in LE? _____
24. ☐ Yes ☑ No **Abnormal deep tendon reflexes in UE?** (If Yes, grade the response below.)
    Bicipital (C5) R:____/L:____/2 Brachioradialis (C6) R:____/L:____/2 Tricipital (C7) R:____/L:____/2
25. ☐ Yes ☐ No **Any sensory changes** to **light touch** and **pinprick in upper extremities?** (If Yes, specify area of decreased sensation below.)
    R / L Lat. arm sensation (C5) R / L Lat. forearm sensation (C6) R / L Middle finger sensation (C7)
    R / L Medial forearm sensation (C8) R / L Medial arm sensation (T1)
26. ☐ Yes ☐ No **Abnormal pulses or capillary refill** in UE? _____
27. ☐ Yes ☐ No **Signs** of apparent **dependent lymphedema**?

General

28. ☐ Yes ☐ No ☐ **Erythema**, ☐ **abrasions**, ☐ **ecchymosis**, ☐ **rash**?
29. ☐ Yes ☑ No Abnormal **abdominal palpation**?
30. ☐ Yes ☐ No Costovertebral angle tenderness for **Renal involvement**?

Explanation of abnormalities and other physical findings:

(+) PLM along the course of (R) sciatic n.
(+) SLR test (R) 90°
(+) R piriformis muscle.

IF I PREMIER PERSONNEL RESOURC 151202
DOS: 6/10/13 DOI: 2/22/13 DOB: 3/26/67
Name: Patient: Santillan, Rosario
Case # : 156-238753 Ref # : FMR/ Yb

CUMENTATION ABOVE.

ACUPUNCTURE SPINE

Date:_____

US HealthWorks MEDICAL GROUP

ACUPUNCTURE LOWER EXTREMITY

Associated Symptoms ☐ None (Check all that apply.)

☐ Yes ☐ No Urinary ☐ Urgency ☐ Frequency ☐ Dysuria ☐ Hematuria ☐ Nocturia ☐ Polyuria ☐ Fever, chills? ☐ Yes ☐ No Bowel/Bladder dysfunction?

☐ Yes ☐ No Paresthesias ☐ Yes ☐ No Weakness ☐ Yes ☐ No Changes in bowel habits ☐ Yes ☐ No Pain radiation to: ______

EXAM: (Check all the statements that apply and **explain any Yes answers** below. If not all items in a statement are positive; check and explain those that apply.)

☑ **Right** ☐ **Left** **Contralateral**

1. ☐ Yes ☑ No **Disoriented** to time, place and person and/or **non-alert**?
2. ☐ Yes ☑ No **Mood and affect** appear **inappropriate**?
3. ☐ Yes ☑ No Abnormal **posture or gait**?

Hip / Thigh

4. ☐ Yes ☑ No ☐ Yes ☐ No ☐ **Erythema**, ☐ **ecchymosis**, ☐ **scars**, ☐ **masses**, or ☐ **swelling**, or ☐ **deformities** in the hip or thigh?
5. ☑ Yes ☐ No ☐ Yes ☐ No ☑ **Tenderness** or ☐ **spasm** musculature of the ☑ buttock or ☑ thigh?
6. ☑ Yes ☑ No ☐ Yes ☐ No ☐ **Tenderness** or ☐ **deformity** of the ☐ **Greater** or ☐ **Lesser Trochanter**?
7. ☐ Yes ☑ No ☐ **Restricted range of motion** of the hip? (If Yes, specify restrictions below.)
   Flexion: R___/L___/135° Extension: R___/L___/30° Abduction R___/L___/45°
   Adduction R___/L___/20° Int. Rotation R___/L___/35° Ext. Rotation R___/L___/45°
8. ☑ Pos ☑ Neg **Straight Leg Raise Test** for sciatic nerve involvement. Right: + at 90 degrees. Left: + at ____ degrees.
9. ☐ Pos ☑ Neg **Anvil Test** for hip or leg pathology.
10. ☐ Pos ☐ Neg **Patrick-Fabere Test** for pathology of sacroiliac joint.

Knees

11. ☐ Yes ☑ No ☐ Yes ☐ No ☐ **Erythema**, ☐ **ecchymosis**, ☐ **scars**, ☐ **masses**, ☐ **swelling** or ☐ **deformities in the knees**?
12. ☐ Yes ☑ No ☐ Yes ☐ No ☐ **Tenderness** of the ☐ **medial and lateral knee joint lines**?
13. ☐ Yes ☑ No ☐ Yes ☐ No ☐ **Patellar subluxation** or ☐ **tenderness**?
14. ☐ Yes ☑ No ☐ Yes ☐ No ☐ **Knee joint effusion** present?
15. ☐ Yes ☑ No **Restrictions to the range of motion**? (If Yes, specify restrictions below.)
    Extension: R___/L___/0° Flexion: R___/L___/135° Int. Rotation: R___/L___/10° Ext. Rotation: R___/L___/10°
16. ☐ Pos ☑ Neg **Abduction/Adduction Stress Tests** for integrity of coll. lig.
17. ☐ Pos ☐ Neg **McMurray Test** for meniscal tears.
18. ☐ Pos ☑ Neg **Bulge Sign / Ballottement Test** for joint effusion.
19. ☐ Pos ☐ Neg **Ant. Post / Drawer Sign** for integrity of cruciate ligament.
20. ☐ Pos ☑ Neg **Apprehension Test** for patellar dislocation or subluxation.
21. ☐ Pos ☐ Neg **Patello-Femoral Grinding Test** for retropatellar pathology.

Ankle / Feet

22. ☐ Yes ☑ No ☐ Yes ☐ No ☐ **Erythema**, ☐ **ecchymosis**, ☐ **scars**, ☐ **swelling**, ☐ **masses**, or ☐ **deformities** in feet or ankles?
23. ☐ Yes ☑ No ☐ Yes ☐ No ☐ Points of **tenderness** in feet or ankles?
24. ☐ Yes ☑ No **Restrictions to the ankle's range of motion**? (If Yes, specify restrictions below.)
    Dorsiflex R___/L___/20° Plantar Flex R___/L___/50° Inversion: R___/L___/30° Eversion: R___/L___/20°
25. ☐ Yes ☑ No **Restrictions to the Great Toe's range of motion**? (If Yes, specify restrictions.) MT: R___/L___ IP: R___/L___
26. ☐ Yes ☑ No **Restrictions to the Lesser Toes' range of motion**? (If Yes, specify restrictions.) Toes#______ MT: R___/L___ IP: R___/L___
27. ☐ Yes ☑ No **Muscle weakness**? (If Yes, grade any weakness.) Dorsiflexion: R___/L___/5 Plantar Flexion: R___/L___/5
28. ☐ Pos ☑ Neg **Eversion Stress Test** for medial instability of ankle.
29. ☐ Pos ☐ Neg **Inversion Stress Test** for lateral instability of ankle.
30. ☐ Pos ☑ Neg **Anterior Drawer Sign** for instability of the ankle joint.
31. ☐ Pos ☐ Neg **Thompson Squeeze Test** for Achilles tendon integrity.

Neurovascular

32. ☐ Yes ☑ No **Abnormal deep tendon reflexes in LE**? (If Yes, grade response.) Patellar (L2, L3, L4) R___/L___/2 Achilles Tendon (S1) R___/L___/2
33. ☑ Yes ☑ No **Any sensory changes to light touch and pinprick** in lower extremities? (If Yes, specify area of decreased sensation below.)
    R / L Anterior Thigh (L1-L3) R / L Medial Leg/Foot (L4) R / L Lateral Leg/Medial Foot (L5)
    (R) / L Lateral Leg/Dorsal Foot (L5) R / L Lateral Ventral Foot (S1) R / L Thoracoabdominal region
34. ☐ Yes ☑ No **Abnormal pulses** in LE? (If Yes, grade the intensity.) Femoral R:___L:___/4 Popliteal R:___L:___/4 Post. Tibial R:___L:___/4
35. ☐ Yes ☑ No ☐ Yes ☑ No ☐ **Signs** of apparent **dependent lymphedema** or ☐ **inguino-crural lymphadenopathy**?
35. ☐ Yes ☑ No ☐ **Signs** of apparent **respiratory distress** (tachypnea, hyperpnea, etc.)?

Explanation of abnormalities and other physical findings:

(+) along the course of (R) sciatic n.
↓ sensation (R) L5
(+) SLR test 90° (R)

PREMIER PERSONNEL RESOURC 151202
DOS: 6/10/13 DOI: 2/22/13 DOB: 3/26/67
Patient: Santillan, Rosario
Case # : 156-238753 Ref # : EMR/ Yb

IF IC... UMENTATION ABOVE.

Name:

ACUPUNCTURE LOWER EXTREMITY

Date: ______

U.S. HealthWorks MEDICAL GROUP

ACUPUNCTURE
Page 2 of 2

DIAGNOSES: (Specify all diagnoses by numbering in order of importance.)

#1 Lumbar Sprain
#2 Right LE radiculopathy
#3
#4
#5
#6

ADDITIONAL COMMENTS:

TREATMENT PLAN:

☐ **Acupuncture Treatment:** 2 times/week for 3 weeks

Procedures:	**Exercise Therapy:**	**Modalities:**	**Other:** Specify:
☑ Acupuncture	☐ Postural education/exercise	☑ Electrical Stimulation	
☑ Electro-Acupuncture	☐ Strengthening	☑ Infrared Heat	
☑ Myofascial Release	☑ Stretching	☐ Hot/Cold Pack	
☐ Joint Mobilization	☐ Stabilization	☐ Vasopneumatic compression	
☐ Neuro Muscular Re-Ed	☐ A/AA/PROm	☐ Traction	
☐ SEMG Biofeedback	☐ Swiss Ball	☐ Paraffin Bath	
☐ Cupping	☐ Home exercise Program		
☐ Individualized Instruction	☐ Body Mechanics/Jt. protection		

Supplies ☐ **The following medical supplies were dispensed and the patient instructed in their proper use:**

☐ Cold Pack ☐ Hot Pack ☐ Lumbar Support ☐ Lumbar Pillow ☐ Foam Roller ☐ Exercise Booklet
☐ Stabilizer ☐ Swiss Ball ☐ Cervical Roll ☐ Theracane ☐ Theraband ☐ Theraputty
☐ Other: ☐ Other:
☐ Other: ☐ Other:

Other:

☐ **Interpreter used** ☐ **Certified interpreter unavailable.** Name:

Work Status: ☐ Regular work ☐ Modified work ☐ Off work. Explain:

☐ **Counseling visit:** Total duration of visit: ____ mins. Total duration of patient counseling: ____ mins.

Return to clinic on:

☐ **Discharged from care.** No further treatment is anticipated at this center at this time.

CONSULT / REFERRAL:

☐ **Patient advised to follow up with personal physician for non-work-related condition.**
Specify:

☐ Suggestion for **Consult / Referral to Specialist** to be discussed with Primary Treating Physician.

☐ Suggestion for **Consult / Referral to PT/OT/Chiro** to be discussed with Primary Treating Physician.

Reasons:

LABELS

ARKADIY GALPERIN, L.A.C.
License Number AC9285

PATIENT EDUCATION:

Patient voiced understanding of: ☑ **possible temporary increase in symptoms, following initial Acupuncture treatment**
☐ **aftercare instructions and expected progression of the injury**
☐ **advised to call US HealthWorks if unexpected symptoms appear after treatment**

EMPLOYER CONTACT: ☐ **Discussed case /** ☐ **Left detailed message with:** on the issues of:

☐ Causation ☐ Diagnoses ☐ Prognosis ☐ Work Status Other:

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License Number AC9285

ACUPUNCTURIST. Signature: Name:

PREMIER PERSONNEL RESOURC 151202
DOS: 6/10/13 DOI: 2/22/13 DOB: 3/26/67
N: Patient: Santillan, Rosario
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DOCUMENTATION ABOVE.

ACUPUNCTURE
Page 2 of 2

I#: Date:

U.S. HealthWorks

PREMIER PERSONNEL RESOURC 151202
DOS: 6/13/13 DOI: 2/22/13 DOB: 3/26/67
Patient: Santillan, Rosario
Case # : 156-238753 Ref # : EMR/ Yb

BIL

Treatment Visit #: 2
Authorized Visit #: 6

ACUPUNCTURE TREATMENT NOTE

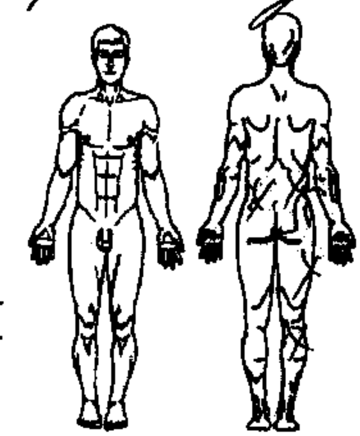
Subjective Pain Level: 0 1 2 3 4 5 6/(7) 8 9 10 Diagnosis: LBP @ L.E radicular simptomatology

LBP → ↓ @ leg

Objective

(T) PLM

(V) along the course of @ sciatic n.



X= Pain S= Spasm T= Trigger

Time	Acupuncture:
	☐ Manual Acupuncture: Needles in:__ out:__ Contact Time:__ Needle Time:__
	☑ Electro-Acupuncture: Needles in: 2 out: 2 Contact Time: 8' Needle Time: 15'
	Needle Points: @ UB 27 - Ashi p.
__	☐ Cupping:
	Modalities:
__	☐ Vaso-Comp/ Edema Control:
__	☐ Electrical Stimulation:
__	☐ Hot Pack/ ☐ Cold Pack / ☐ Ice Massage to:
22'	☑ Infrared Heat: lower back
__	☐ Paraffin Bath:
__	☐ Mechanical Traction:
__	☐ Other:
	Rehabilitation:
21'	☑ (Myofascial Release/Soft Tissue Mobilization) PLM
__	☐ Joint Mobs/ Manual Traction:
__	☐ FAs/ADLs/KAs/Ind. Instruct:
__	☐ Biofeedback:
__	☐ Neuromuscular Reeducation:
__	☐ Supervised Therapeutic Exercises: (Specify):

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet
☐ FCE/Return to Work PAT ☐ PPE (see report) ☐ PePAT (see report)
☐ Other/Supplies:
☑ Skin checked and clear following treatment

ASSESSMENT: ☐ Improving functional capacity (Specify below) ☑ Improving with limitations (Specify below)

PLAN: ☑ Progress Acupuncture treatment program (specify below) ☐ Perform PPE / re-evaluation / D/C summary
☐ D/C from Acupuncture: Has met goals / has reached plateau / is non compliant

ARKADIY GALPERIN, LAc
License Number AC9225

Signature: [signature] License Number: AC 9225

ST 6515 (8/12)

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U.S. H PREMIER PERSONNEL RESOURC 151202
DOS: 6/13/13 DOI: 2/22/13 DOB: 3/26/67
Patient: Santillan, Rosario
Case # : 156-238753 Ref # : EMR/ Yb

BIL

Treatment Visit #: 2
Authorized Visit #: 6

ACUPUNCTURE TREATMENT NOTE

Subjective Pain Level: 0 1 2 3 4 5 6/(7) 8 9 10

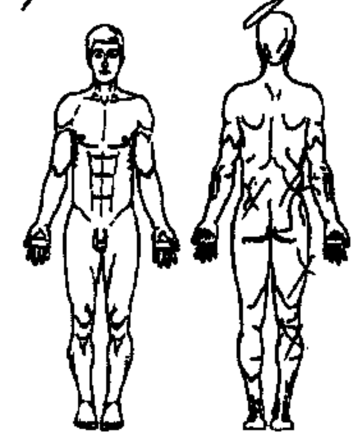
Diagnosis: LBP
@ LE radicular
simptomatology

LBP 7↓ @ Rcp

Objective

(E) PLM

(V) of kup the course of @ Sciatica.



X= Pain S= Spasm T= Trigger

Time **Acupuncture:**

- ☐ Manual Acupuncture: Needles in:__ out:__ Contact Time:__ Needle Time:__
- ☑ Electro-Acupuncture: Needles in: 2 out: 2 Contact Time: 2 Needle Time: 15
  Needle Points: @ UB 22 - Ashi p.
- ___ ☐ Cupping:

Modalities:

- ___ ☐ Vaso-Comp/ Edema Control:
- ___ ☐ Electrical Stimulation:
- ___ ☐ Hot Pack/ ☐ Cold Pack / ☐ Ice Massage to:
- 22' ☑ Infrared Heat: lower back
- ___ ☐ Paraffin Bath:
- ___ ☐ Mechanical Traction:
- ___ ☐ Other:

Rehabilitation:

- 21 ☑ Myofascial Release/Soft Tissue Mobilization PLM
- ___ ☐ Joint Mobs/ Manual Traction:
- ___ ☐ FAs/ADLs/KAs/Ind. Instruct:
- ___ ☐ Biofeedback:
- ___ ☐ Neuromuscular Reeducation:
- ___ ☐ Supervised Therapeutic Exercises: (Specify):

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet
☐ FCE/Return to Work PAT ☐ PPE (see report) ☐ PePAT (see report)
☐ Other/Supplies:
☑ Skin checked and clear following treatment

ASSESSMENT: ☐ Improving functional capacity (Specify below) ☑ Improving with limitations (Specify below)

PLAN: ☑ Progress Acupuncture treatment program (specify below) ☐ Perform PPE / re-evaluation / D/C summary
☐ D/C from Acupuncture: Has met goals / has reached plateau / is non compliant

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Signature: [signature] License Number: AC 9225

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PREMIER PERSONNEL RESOURC 151202
DOS: 6/17/13 DOI: 2/22/13 DOB: 3/26/67
Patient: Santillan, Rosario
Case # : 156-238753 Ref # : EMR/ Yb

BIL

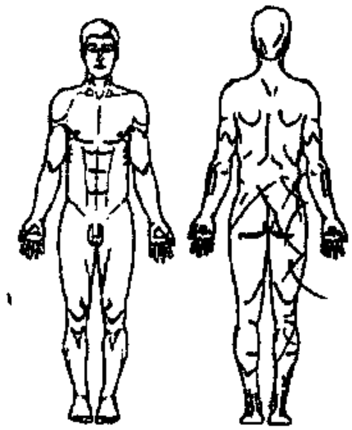
ment Visit #: 7
Authorized Visit #: 6

DAILY ACUPUNCTURE TREATMENT NOTE

Subjective Pain Level: 0 1 2 3 4 5 (6) 7 8 9 10

Diagnosis: LBP

Objective



Time **Acupuncture:**

- ☐ Manual Acupuncture: Needles in:___ out:___ Contact Time:___ Needle Time:___
- ☑ Electro-Acupuncture: Needles in: 2 out: 2 Contact Time: 8 Needle Time: 15
- Needle Points:
- ___ ☐ Cupping:

Modalities:

- ___ ☐ Vaso-Comp/ Edema Control:
- ___ ☐ Electrical Stimulation:
- ___ ☐ Hot Pack/ ☐ Cold Pack / ☐ Ice Massage to:
- 8' ☑ Infrared Heat:
- ___ ☐ Paraffin Bath:
- ___ ☐ Mechanical Traction:
- ___ ☐ Other:

Rehabilitation:

- 8' ☑ Myofascial Release/Soft Tissue Mobilization
- ___ ☐ Joint Mobs/ Manual Traction:
- ___ ☐ FAs/ADLs/KAs/Ind. Instruct:
- ___ ☐ Biofeedback:
- ___ ☐ Neuromuscular Reeducation:
- ___ ☐ Supervised Therapeutic Exercises: (Specify):

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet
☐ FCE/Return to Work PAT ☐ PPE (see report) ☐ PePAT (see report)
☐ Other/Supplies:
☑ Skin checked and clear following treatment

ASSESSMENT: ☐ Improving functional capacity (Specify below) ☑ Improving with limitations (Specify below)

PLAN: ☑ Progress Acupuncture treatment program (specify below) ☐ Perform PPE / re-evaluation / D/C summary
☐ D/C from Acupuncture: Has met goals / has reached plateau / is non compliant

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License Number AC9285

Signature:

License Number: AC9285

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PREMIER PERSONNEL RESOURC 151202
DOS: 6/20/13 DOI: 2/22/13 DOB: 3/26/67
Patient: Santillan, Rosario
Case # : 156-238753 Ref # : EMR/ Yb

BIL

…atment Visit #: 4
…thorized Visit #: 6

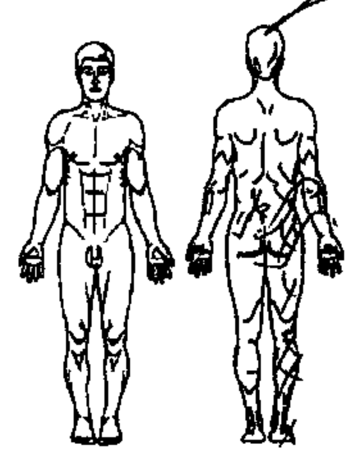
ACUPUNCTURE TREATMENT NOTE

Subjective Pain Level: 0 1 2 3 4 (5 6) 7 8 9 10 …iagnosis: LR D

LRP Eradication to the whole (R) LE (R) LE radiculopathy
give plantar …

Objective

(R) PLM
(R) PLM R 7 L
(R) & (L) (R) … Gluteus …



X= Pain S= Spasm T= Trigger

Time **Acupuncture:**

- ☐ Manual Acupuncture: Needles in:___ out:___ Contact Time:___ Needle Time:___
- ☑ Electro-Acupuncture: Needles in: 8 out: 8 Contact Time: 8' Needle Time: 15'
  Needle Points: (R) UB 25 — 40
- ___ ☐ Cupping: ___

Modalities:

- ___ ☐ Vaso-Comp/ Edema Control: ___
- ___ ☐ Electrical Stimulation: ___
- ___ ☐ Hot Pack/ ☐ Cold Pack / ☐ Ice Massage to: ___
- 20' ☑ Infrared Heat: lower back / LE
- ___ ☐ Paraffin Bath: ___
- ___ ☐ Mechanical Traction: ___
- ___ ☐ Other: ___

Rehabilitation:

- 8' ☑ Myofascial Release/Soft Tissue Mobilization PLM / Glut. … / (R) LE
- ___ ☐ Joint Mobs/ Manual Traction: ___
- ___ ☐ FAs/ADLs/KAs/Ind. Instruct: ___
- ___ ☐ Biofeedback: ___
- ___ ☐ Neuromuscular Reeducation: ___
- ___ ☐ Supervised Therapeutic Exercises: (Specify): ___

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet
☐ FCE/Return to Work PAT ☐ PPE (see report) ☐ PePAT (see report)
☐ Other/Supplies: ___
☑ Skin checked and clear following treatment

ASSESSMENT: ☐ Improving functional capacity (Specify below) ☑ Improving with limitations (Specify below)

PLAN: ☑ Progress Acupuncture treatment program (specify below) ☐ Perform PPE / re-evaluation / D/C summary
☐ D/C from Acupuncture: Has met goals / has reached plateau / is non compliant

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Signature: ___ License Number: AC 9285

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PREMIER PERSONNEL RESOURC 151202
DOS: 6/27/13 DOI: 2/22/13 DOB: 3/26/67
Patient: Santillan, Rosario
Case # : 156-238753 Ref # : EMR/ Yb

BIL

Treatment Visit #: 5
Authorized Visit #: 6

DAILY ACUPUNCTURE TREATMENT NOTE

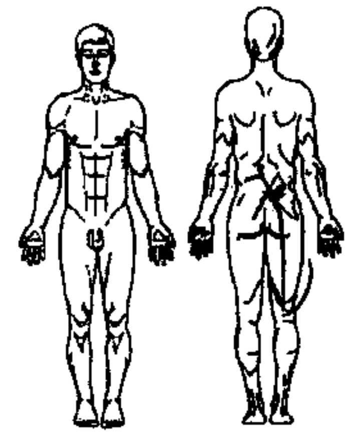
Subjective Pain Level: 0 1 2 3 4 5 6 7 8 9 10

Diagnosis: JI jt (B), Sci...

(R) L bar radiating ↓ (B) LE

Objective

(+) JLR



X= Pain S= Spasm T= Trigger

Time **Acupuncture:**

☐ Manual Acupuncture: Needles in:__ out:__ Contact Time:__ Needle Time:__

☒ Electro-Acupuncture: Needles in: 7 out: 7 Contact Time: 10 Needle Time: 10

Needle Points: LLOB, YTX, Liv3, K3

__ ☐ Cupping:

Modalities:

__ ☐ Vaso-Comp/ Edema Control:

__ ☐ Electrical Stimulation:

__ ☐ Hot Pack/ ☐ Cold Pack / ☐ Ice Massage to:

15 ☒ Infrared Heat: LB

__ ☐ Paraffin Bath:

__ ☐ Mechanical Traction:

__ ☐ Other:

Rehabilitation:

__ ☐ Myofascial Release/Soft Tissue Mobilization

10 ☒ Joint Mobs/ Manual Traction: ext

__ ☐ FAs/ADLs/KAs/Ind. Instruct:

__ ☐ Biofeedback:

__ ☐ Neuromuscular Reeducation:

__ ☐ Supervised Therapeutic Exercises: (Specify):

☒ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet

☐ FCE/Return to Work PAT ☐ PPE (see report) ☐ PePAT (see report)

☐ Other/Supplies:

☐ Skin checked and clear following treatment

ASSESSMENT: ☒ Improving functional capacity (Specify below) ☒ Improving with limitations (Specify below)

PLAN: ☒ Progress Acupuncture treatment program (specify below) ☐ Perform PPE / re-evaluation / D/C summary

☐ D/C from Acupuncture: Has met goals / has reached plateau / is non compliant

Signature: [signature]

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