NEWBORN HISTORY
Birth to 6 months

Today's Date: _____

Patient's Name:_____ Sex: M F Date of Birth:_____ Age:_____

BIRTH HISTORY

How long was the labor from the first regular contraction to the birth? _____ hours

How long was the 2nd stage (the pushing phase) of the labor? _____ hours

Yes	No		Yes	No		Yes	No	
☐	☐	Hospital Birth	☐	☐	Vaginal Delivery	☐	☐	Was birth induced (Pitocin)
☐	☐	Home Birth	☐	☐	Planned C-section	☐	☐	Forceps Delivery
☐	☐	Midwife Assisted	☐	☐	Emergency C-section	☐	☐	Vacuum Extraction
☐	☐	Anesthesia Administered	☐	☐	Head Presentation			
☐	☐	Fetal Distress	☐	☐	Face Presentation			
☐	☐	Meconium Staining	☐	☐	Breech Presentation			

BABY'S CONDITION IMMEDIATELY AFTER BIRTH:

Apgar Scores: At 1 minute _____ / 10 At 5 minutes _____/ 10

Baby's Crying: Baby cried immediately after birth:_____

Cried strongly:_____ week cry:_____ did not cry for _____ minutes

Baby's Color: Pink all over:_____ Blue face:_____ Blue hands/feet:_____

Baby's Activity: Arms and legs actively moving_____ Floppy baby_____

Intensive Care: Was required: Y N Days in Neonatal Intensive Care Unit:_____

Medication given at birth: _____ Vaccines administered:_____

Birth weight:_____ lbs/kgs Birth length:_____ ins/cms Baby home on day:_____

HEALTH HISTORY

Primary Complaint:_____ Onset:_____

How many hours does your baby sleep between feedings? During day:_____ At night:_____

Yes	No	
☐	☐	Does your baby go to sleep easily? _____
☐	☐	Does baby have a preferred sleeping position? _____
☐	☐	Does baby cry if you change this sleeping position? _____
☐	☐	Does baby have any feeding difficulties? _____
☐	☐	Is baby being breast fed? _____ If no, for how long was baby breast fed_____ weeks/ months
☐	☐	Does baby have a one sided breast-feeding preference? _____ Preferred breast: Left / Right
☐	☐	Is baby formula fed? _____ Which formula or other milk source?_____
☐	☐	Does baby frequently spit-up after feeding?_____
☐	☐	Does your baby cry a lot? For how many hours each day?_____
☐	☐	Does baby pass a lot of intestinal gas?_____
☐	☐	Does baby have a preferred head position?_____
☐	☐	Does baby frequently arch his/her head and neck backwards? _____
☐	☐	Does baby cry or become irritable during a diaper change? _____
☐	☐	Has baby ever had a fever? _____
☐	☐	Has baby had any falls? _____
☐	☐	Has baby been in a car accident or near-miss? _____
☐	☐	Has baby had any other trauma? _____
☐	☐	Has your baby been vaccinated? _____
☐	☐	Do you have any other concerns you wish to discuss? _____

NEWBORN PHYSICAL EXAMINATION
Birth to 6 months

Today's Date:_____

Child's Name:_____

Temp_____ Length_____ Weight:_____ Head Circ:_____ Pulse_____ Resp_____ BP_____/_____

Check a box to indicate a problem and describe or comment below. If no abnormality detected check box NAD.

Skin
- ☐ Rash
- ☐ Marks
- ☐ Dehydration
- ☐ Cyanosis
- ☐ Jaundice – day___
- ☐ NAD

Head
- ☐ Head size
- ☐ Swelling/bruising
- ☐ Ant. fontanelle
- ☐ Post. fontanelle
- ☐ Craniosynostosis
- ☐ NAD

Head Shape
- ☐ Flattened occiput
- ☐ Eccentric
- ☐ Depressed frontal
- ☐ Cone / elongated
- ☐ Broad / wide
- ☐ Average / NAD

Head/ Neck
- ☐ Torticollis
- ☐ Lateral tilt
- ☐ Persistent Rotation
- ☐ Hyperextension
- ☐ Restricted motion
- ☐ NAD

_____

_____

Face
- ☐ Bell's palsy
- ☐ Eyelid Ptosis
- ☐ Conjunctivitis
- ☐ Nose
- ☐ Lips
- ☐ NAD

Eyes
- ☐ Vision
- ☐ Tracking
- ☐ Pupil deviation
- ☐ Pupillary response
- ☐ Red reflex
- ☐ NAD

Ears
- ☐ Structure
- ☐ Position
- ☐ External canal
- ☐ Otoscopic exam
- ☐ Hearing
- ☐ NAD

Mouth
- ☐ Sucking
- ☐ Swallowing
- ☐ Gag reflex
- ☐ Tongue movement
- ☐ Palate high/ low
- ☐ NAD

_____

_____

Upper Extremity
- ☐ Flexion
- ☐ Asymmetry
- ☐ Range of motion
- ☐ Hypotonia
- ☐ "Jittery"
- ☐ NAD

Thorax/Abdomen
- ☐ Clavicle Fracture
- ☐ Chest shape
- ☐ Breath sounds
- ☐ Heart murmur
- ☐ Abdominal exam
- ☐ NAD

Lower Extremity
- ☐ Inguinal skin folds
- ☐ Hip joint motion
- ☐ Legs
- ☐ Knees
- ☐ Ankles & Feet
- ☐ NAD

Pelvis
- ☐ Gluteal cleft
- ☐ Gluteal folds
- ☐ Leg length
- ☐ Sacrum
- ☐ Sacroiliac joints
- ☐ NAD

_____

_____

Deep Tendon Reflexes

	0	1+	2+	3+
Biceps	☐	☐	☐	☐
Patella	☐	☐	☐	☐
Achilles	☐	☐	☐	☐

Primitive Reflexes Check IPP box if reflex is absent, asymmetrical or sustained

NAD	IPP		NAD	IPP		NAD	IPP		NAD	IPP	
☐	☐	Blink	☐	☐	Tonic neck	☐	☐	Suspension	☐	☐	Galant
☐	☐	Acoustic blink	☐	☐	Palmar grasp	☐	☐	Placing	☐	☐	Anal
☐	☐	Rooting	☐	☐	Moro	☐	☐	Stepping	☐	☐	Babinski

Cranial Faults

L	R	
☐	☐	Frontal
☐	☐	Parietal
☐	☐	Temporal
☐	☐	Occiput
☐	☐	Sphenoid

Sutures

L	R	
☐	☐	Coronal
☐	☐	Lambdoid

A	P	
☐	☐	Metopic
☐	☐	Sagittal

Spinal Exam

_____ C0 _____
_____ C1 _____
_____ C2 _____
_____ C3 _____
_____ C4 _____
_____ C5 _____
_____ C6 _____
_____ C7 _____
_____ T1 _____
_____ T2 _____
_____ T3 _____
_____ T4 _____
_____ T5 _____
_____ T6 _____
_____ T7 _____
_____ T8 _____
_____ T9 _____
_____ T10 _____
_____ T11 _____
_____ T12 _____
_____ L1 _____
_____ L2 _____
_____ L3 _____
_____ L4 _____
_____ L5 _____
_____ Sac _____
_____ SI _____

Indicate
Scoliosis
Subluxation
Muscle tension

INFANT HISTORY

Today's Date: _______ **7 months to 3 years**

Patient's Name:_____ Sex: M F Date of Birth:_____ Age:_____

HEALTH HISTORY

Chief Complaint:_____ Onset:_____

Yes No

- ☐ ☐ Has your child had colic?_____
- ☐ ☐ Has your child had any upper respiratory infections? How often?_____
- ☐ ☐ Has your child had asthma? _____
- ☐ ☐ Does your child ever complain of back or neck pain?_____
- ☐ ☐ Does your child ever complain of pains in the arms or legs? _____
- ☐ ☐ Does your child ever complain of headaches? _____
- ☐ ☐ Has your child had any earaches? At what age did the first earache occur?_____
- ☐ ☐ How frequently does your child have earaches? _____
- ☐ ☐ Does your child's earaches usually tend to occur in the same ear? Is it the: ☐ right ☐ left ☐ or both
- ☐ ☐ How your child had any other illnesses? Please list each illness and its approximate date: _____
  _____
- ☐ ☐ Is your child presently receiving any medication? _____
- ☐ ☐ Has your child ever been to a hospital or emergency room for evaluation or treatment?
- ☐ ☐ Has your child recently been vaccinated?

NUTRITION

- ☐ ☐ Is your child still being breast fed? If no, for how long was he/she breast fed? _____
  If still breast-feeding, how much cow's milk does the mother consume each day? _____
- ☐ ☐ Is your child formula fed? Which formula or other milk source? _____
- ☐ ☐ Is your child eating solid food? What is your child's favorite food? _____
  What foods does his/her diet contain? _____
- ☐ ☐ Does your child have any feeding difficulties? _____
- ☐ ☐ Does your child have any digestive disturbances? _____
- ☐ ☐ Does your child have any food allergies? _____
- ☐ ☐ Does your child have any persistent or intermittent skin rashes? _____
- ☐ ☐ Is your child receiving any vitamin supplements? _____

TRAUMA

- ☐ ☐ Has your child had any recent falls or trauma? If yes, describe the trauma and the date it occurred?_____
  _____
- ☐ ☐ Has your child ever fallen down stairs or fallen from any height?_____
- ☐ ☐ Has your child ever been in a motor vehicle collision or near-miss?_____
- ☐ ☐ Has your child ever had a bone fracture or joint dislocation?_____
- ☐ ☐ Has your child had any other trauma or injuries?_____
- ☐ ☐ Does your child ever bang his/her head repeatedly against a wall, bed or other object?_____

GROWTH AND DEVELOPMENT

- ☐ ☐ Can your child sit unsupported? At what age did your child start to sit-up? _____mths.
- ☐ ☐ Is your child crawling yet? At what age did your child start crawling? _____mths.
- ☐ ☐ Is your child walking yet? At what age did your child start to walk? _____mths.
- ☐ ☐ Does your child often trip and fall?_____
- ☐ ☐ Do you have any other concerns about your child's growth and development?_____
  _____
- ☐ ☐ Do you have any other concerns about your child's health?

INFANT PHYSICAL EXAMINATION
7 months to 3 years

Today's Date:_____

Child's Name:_____

Check a box to indicate "no abnormality" or "within normal limits", otherwise write comment.

Head / Neck
- ☐ Head size_____
- ☐ Head shape _____
- ☐ Head position_____
- ☐ Neck ROM_____
- ☐ Lympth nodes_____

Upper Extremities
- ☐ Alignment_____
- ☐ Active ROM_____
- ☐ Passive ROM _____
- ☐ Muscle tone _____
- ☐ Co-ordination _____

Posture
- ☐ Ear level _____
- ☐ Should level_____
- ☐ Scapulae_____
- ☐ Iliac crests_____
- ☐ Kyphosis_____
- ☐ Lordosis _____
- ☐ Scoliosis check _____

Lower Extremities
- ☐ Gait _____
- ☐ Co-ordination_____
- ☐ Alignment (seated)_____
- ☐ Patellar reflex_____
- ☐ Ortolani / Barlow tests_____
- ☐ Leg length_____
- ☐ Heel-to-buttock test_____

Skin
- ☐ Rashes _____
- ☐ Marks _____
- ☐ Pinch test _____
- ☐ Cyanosis _____

Eyes
- ☐ Vision – near / far _____
- ☐ Cover – uncover test _____
- ☐ Pupil alignment _____
- ☐ Tracking _____

Spinal Exam

_____ C0 _____
_____ C1 _____
_____ C2 _____
_____ C3 _____
_____ C4 _____
_____ C5 _____
_____ C6 _____
_____ C7 _____
_____ T1 _____
_____ T2 _____
_____ T3 _____
_____ T4 _____
_____ T5 _____
_____ T6 _____
_____ T7 _____
_____ T8 _____
_____ T9 _____
_____ T10 _____
_____ T11 _____
_____ T12 _____
_____ L1 _____
_____ L2 _____
_____ L3 _____
_____ L4 _____
_____ L5 _____
_____ Sac _____
_____ SI _____

Indicate
Scoliosis
Subluxation
Muscle tension

Spinal Examination

	Cervical			Thoracic			Lumbar		
	L	B/L	R	L	B/L	R	L	B/L	R
Myospasm palpable	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tenderness to palpation	☐	☐	☐	☐	☐	☐	☐	☐	☐

Vital Signs
Temp____ Height_____ Weight_____ Head circumf._____ Pulse_____ Resp_____ BP____/____

Otoscopic Exam

	WNL	Impacted	Erythema				Light reflex			
Left ear	☐	☐	mild ☐	☐	☐	severe	Normal ☐	Abn ☐	Absent ☐	
Right ear	☐	☐	mild ☐	☐	☐	severe	Normal ☐	Abn ☐	Absent ☐	

Hearing ☐ Tuning fork _____ ☐ Locates sound_____

Recommended further testing

☐ X-rays_____ ☐ Lab test_____

Diagnosis:_____

Treatment plan:_____

_____

Cranial Exam
Open Fontanelles
- ☐ Anterior
- ☐ Posterior

Cranial Bones

L	R	
☐	☐	Frontal
☐	☐	Parietal
☐	☐	Temporal
☐	☐	Occiput
☐	☐	Sphenoid

Sutures

L	R	
☐	☐	Coronal
☐	☐	Lambdoid
A	P	
☐	☐	Metopic
☐	☐	Sagittal

PRE-SCHOOL CHILD HISTORY

Today's Date:_____ **3 years to 5 years**

Child's Name:_____ Sex M F Date of Birth_____ Age_____

HEALTH HISTORY

Well-child Exam ☐ Primary Complaint:_____ Onset:_____

Yes No

☐ ☐ Does your child complain of pain or discomfort? If yes, when did this occur?_____
Was onset: ☐ Sudden ☐ or Gradual Is problem: ☐ Constant ☐ or Intermittent

☐ ☐ Has your child ever had this problem before?_____

☐ ☐ Has your child previously been treated for this problem? By whom?_____

☐ ☐ Has your child previous had chiropractic care? Previous Chiropractor:_____

☐ ☐ Does your child ever complain of back or neck pain? _____

☐ ☐ Does your child ever complain of pains in the legs or arms? _____

☐ ☐ Does your child ever complain of headaches? _____

☐ ☐ Has your child had asthma? _____

☐ ☐ Is your child allergic to anything? _____

☐ ☐ Are there any smokers in the child's home? _____

☐ ☐ Has your child had any earaches? At what age did the child's first earache occur:____

How frequently does your child have earaches? _____

In which ear do your child's earaches usually occur? ☐ Right ☐ Left ☐ Both

☐ ☐ Is your child presently taking any prescribed medication?_____

☐ ☐ Do you have any other concerns about your child's health?

Please list any other illness which has been a concern for your child.

Please list any surgeries your child has had

TRAUMA

☐ ☐ Has your child had any recent falls or trauma? Describe the trauma and the date if occurred_____

_____

☐ ☐ Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar?_____

☐ ☐ Has your child ever fallen down stairs or fallen from a significant height?_____

☐ ☐ Has your child ever been in a motor vehicle collision or near-miss?_____

☐ ☐ Has your child ever had a bone fracture or joint dislocation?_____

☐ ☐ Has your child had any other trauma or injuries?_____

☐ ☐ Does your child ever bang his/her head repeatedly against a wall, bed or other object?_____

NUTRITION

☐ ☐ Do you have any concerns about your child's diet?_____

☐ ☐ Does your child have any food allergies? _____

☐ ☐ Does your child have any persistent or intermittently occurring skin rashes? _____

☐ ☐ Does your child take vitamin supplements? _____

☐ ☐ Does your child eliminate stools each day? _____

For how many months was your child breast-fed? _____

What does your child usually eat for Breakfast? _____

What does your child usually eat for Lunch? _____

What does your child usually eat for Dinner? _____

What does your child usually ear for Snacks? _____

How much cow's milk does your child drink each day? _____

What is your child's favorite food? _____

What type of fast foods does your child like to eat? _____

PRE-SCHOOL PHYSICAL EXAMINATION
3 years to 5 years

Today's Date:_____

Child's Name:_____

WNL **Posture**
- ☐ Head / Neck position_____
- ☐ Ear level _____
- ☐ Shoulder level_____
- ☐ Scapulae_____

Kyphosis _____
- ☐ Lordosis _____
- ☐ Scoliosis check _____
- ☐ Illiac crests _____

Range of Motion:

	Cervical WNL	Cervical R	Cervical P	Thoraco-Lumbar WNL	Thoraco-Lumbar R	Thoraco-Lumbar P
Flexion	☐	___/___		☐	___/___	
Extension	☐	___/___		☐	___/___	
Rotation – Rt	☐	___/___		☐	___/___	
Rotation – Lt	☐	___/___		☐	___/___	
Lat. flexion – Rt	☐	___/___		☐	___/___	
Lat. flexion – Lt	☐	___/___		☐	___/___	

For each movement indicate if WNL… Restricted or Painful

WNL **Lower Extremities (Standing)**
- ☐ Gait_____
- ☐ Co-ordination _____
- ☐ Knee position _____
- ☐ Ankle / Foot position _____

WNL **Lower Extremities (Seated)**
- ☐ Ankle / Foot alignment_____
- ☐ Stretch Reflexes Patellar R___ L___
  Achilles R___ L___

WNL **Lower Extremities (Supine)**
- ☐ Leg length Rt.___ins/cms Lt.___ins/cms
- ☐ Hip ROM_____
- ☐ Knee ROM _____
- ☐ Ankle / Foot ROM_____

WNL **Lower Extremities (Prone)**
- ☐ Femoral torsion_____
- ☐ Tibial torsion_____
- ☐ Leg Length ☐ Rt. Short ☐ Lt. short
- ☐ Derefield ☐ R+ ☐ L+ ☐ R- ☐ L-
- ☐ Heel-to-buttock restriction ☐ Rt ☐ Lt

WNL **Neck**
- ☐ Muscle spasm _____
- ☐ Tenderness _____
- ☐ Lymph nodes _____

WNL **Upper Extremities**
- ☐ Shoulder ROM_____
- ☐ Elbow ROM_____
- ☐ Stretch Reflexes Biceps R___ L___
- ☐ Triceps R__ L__ Br'radialis R__ L__
- ☐ Muscle tone_____

WNL **Eyes**
- ☐ Vision – near / far_____
- ☐ Cover-uncover test_____

WNL **Ears**
- ☐ Rinne test_____
- ☐ Weber test_____

Otoscopic Exam

WNL	Impacted	Erythema	Light reflex abnormal
☐ Rt.Ear	☐	☐	☐
☐ Lt Ear	☐	☐	☐

Spinal Exam
Indicate
Listing (PR, etc)
M uscle tension
T enderness
S coliosis

_____ C0 _____
_____ C1 _____
_____ C2 _____
_____ C3 _____
_____ C4 _____
_____ C5 _____
_____ C6 _____
_____ C7 _____
_____ T1 _____
_____ T2 _____
_____ T3 _____
_____ T4 _____
_____ T5 _____
_____ T6 _____
_____ T7 _____
_____ T8 _____
_____ T9 _____
_____ T10 _____
_____ T11 _____
_____ T12 _____
_____ L1 _____
_____ L2 _____
_____ L3 _____
_____ L4 _____
_____ L5 _____
_____ Sac _____
_____ SI _____

Cranial Exam

L	R	
☐	☐	Frontal
☐	☐	Parietal
☐	☐	Temporal
☐	☐	Occiput
☐	☐	Sphenoid

TMJ Exam

L	R	
☐	☐	Deviation
☐	☐	Hypermobility
☐	☐	Tenderness

Vital Signs
Height_____ Weight_____ Temp_____ Pulse _____ Resp_____ BP_____/_____

Further Testing
☐ X-rays_____ ☐ Lab tests_____

Diagnosis_____

Treatment Plan _____

Check the WNL box if exam results are normal – otherwise, briefly document the problem.

SCHOOL-AGE CHILD HISTORY

Today's Date:_____ **6 years and Older**

Child's Name:_____ Sex M F Date of Birth_____ Age_____

Reason for today's visit:_____

When did this problem first occur?_____

Yes No

☐ ☐ Have you ever had this problem before?_____
☐ ☐ Have you previously been treated for this problem? Doctors Name: _____
☐ ☐ Have you previously been to a chiropractor? When: _____

ABOUT YOUR HEALTH

In the past year have you had any of the following.

☐ ☐ Back or neck pain? _____
☐ ☐ Pains in the legs or arms? _____
☐ ☐ Headaches? _____
☐ ☐ Asthma? _____
☐ ☐ Allergies? _____
☐ ☐ Earaches? _____
☐ ☐ Falls from a bicycle, skateboard, scooter, rollerblades or similar? _____
☐ ☐ Do you ever have a problem with bedwetting? _____
☐ ☐ Have you ever been in a motor vehicle accident? _____
☐ ☐ Have you ever had any broken bones? _____
☐ ☐ Have you ever had any surgeries? _____
☐ ☐ Are you at present taking any medications?_____
☐ ☐ Do you have any other health problems? _____

ABOUT YOUR LIFESTYLE

What grade are you in at school?_____
How do you carry your school books?_____
How heavy is your school book bag?_____
What sports do you play?_____
What hobbies do you have?_____
How many hours each day to you watch TV?_____
How many hours each day do you spend using a computer?_____
How often do you play video games?_____
On average, how many hours sleep do you get each night?_____
Are there any smokers in your family?_____
Do you feel stressed out?_____
Do you have trouble reading the board in class?_____
Do you ever have blurred vision?_____
Do you wear glasses or contact lenses?_____
Do you sometimes get headaches when you read?_____
What do you usually eat for Breakfast? _____
What do you usually eat for Lunch? _____
What do you usually eat for Dinner? _____
What snacks do you have after school? _____
What is your favorite food? _____
How much water do you drink each day?_____
How many sodas or colas do you drink each day?_____
How often do you eat fast food items? _____

SCHOOL-AGE PHYSICAL EXAMINATION

Today's Date:_____ **6 years and Older**

Child's Name:_____

Well-child Exam ☐ Chief Complaint:_____ Onset:_____

WNL **Posture**
- ☐ Head / Neck position_____
- ☐ Ear level _____
- ☐ Shoulder level_____
- ☐ Scapulae_____
- ☐ Kyphosis _____
- ☐ Lordosis _____
- ☐ Scoliosis check _____
- ☐ Illiac crests _____

Range of Motion:

	Cervical WNL	Cervical R	Cervical P	Thoraco-Lumbar WNL	Thoraco-Lumbar R	Thoraco-Lumbar P
Flexion	☐	___/___		☐	___/___	
Extension	☐	___/___		☐	___/___	
Rotation – Rt	☐	___/___		☐	___/___	
Rotation – Lt	☐	___/___		☐	___/___	
Lat. flexion – Rt	☐	___/___		☐	___/___	
Lat. flexion – Lt	☐	___/___		☐	___/___	

For each movement indicate if WNL… Restricted or Painful

WNL **Lower Extremities (Standing)**
- ☐ Gait_____
- ☐ Co-ordination _____
- ☐ Knee position _____
- ☐ Ankle / Foot position _____
- ☐ Sacroiliac ROM (Step test)_____

WNL **Lower Extremities (Seated)**
- ☐ Ankle / Foot alignment_____
- ☐ Stretch Reflexes Patellar R___ L____
  Achilles R___ L____

WNL **Lower Extremities (Supine)**
- ☐ Hip ROM (Fabere) _____
- ☐ Hip/ SI joint (Gaenslen) _____
- ☐ Straight leg raise _____
- ☐ Knee ROM _____
- ☐ Knee ligaments_____
- ☐ Ankle / Foot ROM_____
- ☐ Cross crawl_____
- ☐ Leg Length: Rt.____ins/cms Lt._____ins/cms

WNL **Neck (Seated)**
- ☐ Muscle spasm _____
- ☐ Tenderness _____
- ☐ Lymph nodes _____
- ☐ Compression test_____
- ☐ Distraction test_____

WNL **Upper Extremities (Seated)**
- ☐ Shoulder ROM (Apley)_____
- ☐ Scapular ROM _____
- ☐ Forearm ROM_____
- ☐ Stretch Reflexes Biceps R___ L___
  Triceps R__ L__ Br'radialis R_ L___
- ☐ Muscle strength_____

WNL **Lower Extremities (Prone)**
- ☐ Femoral torsion _____
- ☐ Tibial torsion _____
- ☐ Leg length ☐ Rt. Short ☐ Lt short
- ☐ Derefield ☐ R+ ☐ L+ ☐ R- ☐ L-
- ☐ Heel-to buttock restriction ☐ Rt. ☐ Lt

Spinal Exam
Indicate
Listing (PR, etc)
M uscle tension
T enderness
S coliosis

_____ C0 _____
_____ C1 _____
_____ C2 _____
_____ C3 _____
_____ C4 _____
_____ C5 _____
_____ C6 _____
_____ C7 _____
_____ T1 _____
_____ T2 _____
_____ T3 _____
_____ T4 _____
_____ T5 _____
_____ T6 _____
_____ T7 _____
_____ T8 _____
_____ T9 _____
_____ T10 _____
_____ T11 _____
_____ T12 _____
_____ L1 _____
_____ L2 _____
_____ L3 _____
_____ L4 _____
_____ L5 _____
_____ Sac _____
_____ SI _____

Cranial Exam

L	R	
☐	☐	Frontal
☐	☐	Parietal
☐	☐	Temporal
☐	☐	Occiput
☐	☐	Sphenoid

TMJ Exam

L	R	
☐	☐	Deviation
☐	☐	Hypermobility
☐	☐	Tenderness

Vital Signs
Height_____ Weight_____ Temp_____ Pulse _____ Resp_____ BP_____/_____

Radiography
- ☐ Views _____

Laboratory Testing
- ☐ Tests_____

Diagnosis_____

Plan _____

_____