Back To Chiropractic CE Seminars

History & Examination ~ 4 Hours

Welcome to Back To Chiropractic Online CE exams:

This course counts toward your California Board of Chiropractic Examiners CE.
(also accepted in other states, check our website or with your Chiropractic State Board)

The California Board requires that you complete all of your CE hours BEFORE the end of your Birthday month. We recommend that you send your chiropractic license renewal form and fee in early to avoid any issues.

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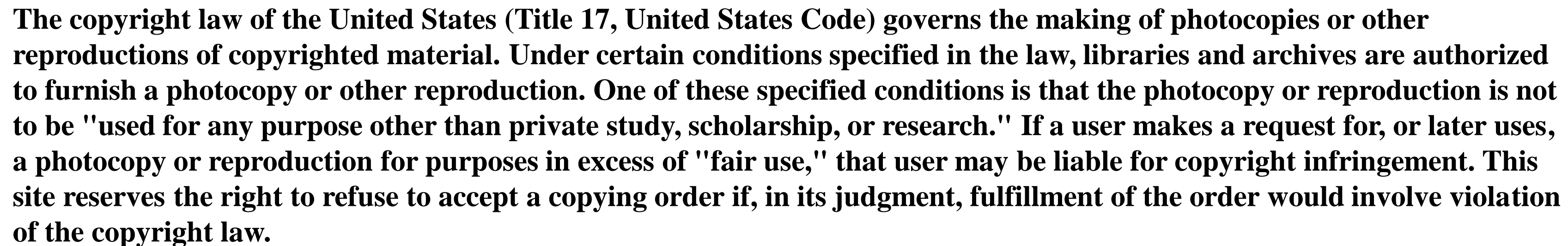

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1. You must register/pay first. If you haven't, please return to: backtochiropractic.net

2. Open a new window or a new internet tab & drag it so it's side-by-side next to this page.

3. On the new window or new tab you just opened, go to: backtochiropractic.net website.

4. Go directly to the Online section. DON'T register again.

5. Click on the Exam for the course you want to take. No passwords needed.

6. Follow the Exam instructions.

7. Upon passing exam (70%), you'll be able to immediately download your certificate, and it'll also be emailed to you. If you don't pass, you must repeat the exam.

   Please retain the certificate for 5 years. DON'T send it to the state board. If you get audited and lose your records, I'll have a copy.

I'm always a phone call away... 707.972.0047 or email: marcusstrutzdc@gmail.com

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History and Examination

Dr. Michelle J. Massa, DC, CEES

Introduction

- Education & Background
  - Psychology, Lifestyle, Nutrition & Wellness
    - Neuropsychology & Behavioral Psychology
    - Health Education – Adult Weight Management
  - HIPAA, Ethics and Law, History, Exam, Diagnosis & Documentation
    - Compliance Officer – Life West Health Center
  - Certified Ergonomist
    - Ergonomic Evaluations
    - Ergonomic & Workplace Safety Trainings
- www.MichelleJMassa.com

Housekeeping

- Bathrooms
- Breaks
- Continuing Education hours
- Teaching style & format

Goals and Objectives

- A thorough understanding of history taking techniques and best practices for documenting complaints vs a wellness or asymptomatic patient
- Gain clarification on the development of a working primary diagnosis including a differential diagnosis and the development of the hierarchy of diagnosis
- Differentiate which spinal & extremity exams are appropriate for the complaint based patient versus a wellness/asymptomatic patient.
- Documentation in relation to outcome goals and progression through care as well as best practices for referring of patients for co-management.

Overview

- Focused History
- Critical thinking in the consideration of diagnosis and differential diagnosis
- Complaint based spinal and extremity chiropractic exam
- Wellness or asymptomatic spinal and extremity exam

Assessment – The Process of Clinical Thinking

- What is wrong with the patient? What are the problems?
- Identify the abnormal findings
  - Symptoms reported by the patient in the history
  - Signs observed by the clinician during the exam
  - Laboratory reports available
- Localize the findings anatomically
  - Body system – Body region – Exact structure

Assessment – The Process of Clinical Thinking

- Interpret findings in terms of probable process
  - Pathological
    - Congenital, inflammatory, immunologic, neoplastic, metabolic, nutritional, degenerative, vascular, traumatic, toxic
  - Pathophysiological
    - Dysfunction of a physiological system
  - Psychopathological
    - Mood or thought process

Assessment – The Process of Clinical Thinking

- Make a hypothesis
  - Central findings
  - Match findings against all conditions you know can produce them
  - Eliminate the possibilities that do not fit the findings
  - Weight the competing possibilities
    - Close match
    - Statistical probability
    - Timing
  - Special attention
    - Less probable yet important
- Test your hypothesis (more History, Exam & Labs)

History

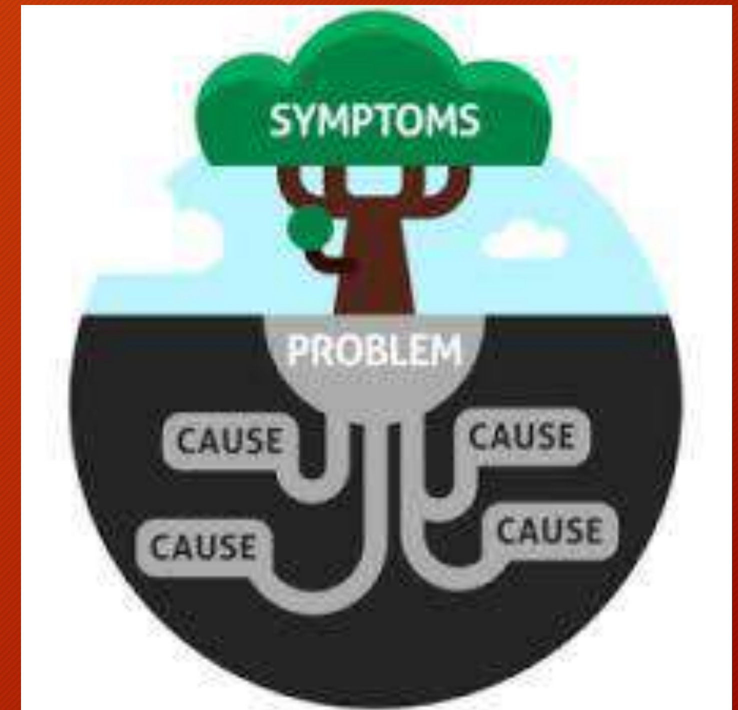
History – Structure & Purpose

- Are you a Primary Care Wellness Doctor or a Subspecialist?
  - As a wellness doctor you will focus on additional health maintenance issues whereas a subspecialist will focus on neurological & MS issues.
  - Both require a thorough history in order to acquire all of the pertinent& relevant information needed to address a patient's specific concern
- Identifying data
  - Age, birthplace, occupation, etc.
  - Referral source

Bates Guide to Physical Examination & History Taking

History – Structure & Purpose

- Chief Complaints
  - Present/Active
    - Chronological, attributes & context
    - How the patient feels about it, concerns that led to seeking care, how it has affected ADL and functions
  - Past
    - Childhood illness
    - Adult medical illness
    - Surgery
    - OB/GYN or Male health
    - Psychiatric
    - Accidents/Injuries
    - Immunizations/screening exams
    - Lifestyle



Bates Guide to Physical Examination & History Taking

History – Structure & Purpose

- Family History
  - Risk of disease
- Personal & Social History
  - Education, family of origin, current household, interests & hobbies
- Review of Systems
  - Common symptoms in each body system
  - It is important to differentiate what the patient knows that they have vs. presenting symptoms
    - Ex: I have hypothyroidism vs Experiencing lethargy, feeling cold, weight gain, etc.

Bates Guide to Physical Examination & History Taking

History – Structure & Purpose

- The Stages of the Patient Interview
  - Greet & establish rapport
  - Inviting the patient's story
  - Establishing the agenda fr the interview
  - Generating & testing hypothesis about the nature of the problem(s) by expanding and clarifying the patient's story
  - Creating a shared understanding of the problem(s)
  - Negotiating a plan (includes further diagnostic evaluation, treatment & patient education)
  - Planning the follow up and closing the interview

Bates Guide to Physical Examination & History Taking

Eliciting the Patient’s Perspective

- The patient’s thought about the nature and cause of the issue
- The patient’s feelings about the issue, esp. fears
- The patients’ expectations of the clinician & manner of care
- The effects of the issue on the patient’s life
- Similar experiences in personal or family history
- Steps taken by the patient to address the issue

History – Gathering Information

- Onset
  - Trauma
  - Overuse
  - Insidious
- Clarify the type of concern
  - Quality
    - Pain, Numbness or Tingling, Stiffness, Looseness, Crepitus, Locking, or a combination?
  - Location
    - Anterior, Posterior, Medial, Lateral

The 7 Attributes of a Symptom

- Location – where & does it radiate
- Quality
- Severity
- Timing – onset, how long does it last, how often does it occur
- Setting – environmental factors, personal activities
- Provocative & Palliative
- Associated manifestations
- OPQRST

Bates Guide to Physical Examination & History Taking

Musculoskeletal Complaints/Concerns

- Acute traumatic pain
  - Rule in/out
    - Fracture & associated neural & vascular damage
    - Dislocation
    - Gross instability
- Non-traumatic pain
  - Rule in/out
    - Tumor
    - Inflammatory arthritides
    - Infections
    - Visceral referral

Traumatic Injuries

- If there was a fall…
  - Fracture
  - Dislocation
  - Contusion
- Determine if there was excessive: valgus or varus force, internal or external rotation, flexion or extension
  - Ligament/capsule
  - Muscle/tendon

Traumatic Injury Exam findings

- Palpate for point tenderness & test for neovascular status distal to the site of injury
- Palpate for swelling, masses, warmth
  - Masses – bony v ST
  - ST – lipomas, neuromas, ganglions or fascial herniations
- Edema – is it intra or extra articular
  - If extra articular determine if it is bursal or vascular inflammation
- Palpate & challenge the capsule & ligaments
- Check musculo-tendon attachments for contraction v stretch
- Measure the functional capacity of the region

Overuse Injuries

- In what position does the patient work (Ergonomics)
- Does the patient perform repetitive movements
  - Work or Hobbies
    - Muscle strain
    - Tendinitis
    - Trigger points
    - Peripheral nerve entrapments

Insidious Onset Injuries

- Fever, Malaise/fatigue, lymphadenopathy, multiple affected areas
- Local signs of inflammation (redness, edema, heat)
- Local deformity
- Associated weakness, numbness, tingling, or other neurological dysfunction

Weakness

- Consider
  - Pain inhibition
  - Muscle strain
  - Neurologic interruption at myoneural junction
  - Peripheral nerve
  - Nerve root
  - Spinal cord
  - Instability of a joint

Instability

- Trauma
- Global
  - Will be found in various joints in the body

Restricted Movements

- Pain
- Muscle spasm
- Stretching
- ST Contracture
- Blockage by osteophytes, joint mice, fracture or effusion

Pain

- Local v Referred
  - Scleratogenous referred pain
    - Non-dermatomal pattern
    - No neurological findings (mm strength & DTRs normal)
    - AKA Disc & Facet pain
  - Visceral referred pain
    - Ask questions to determine if there is a secondary compliant/concern
  - Bone pain
    - Deep pain worse in the evening
    - Trauma → fracture, Overuse →stress fracture
    - Stress fractures may require a bone scan

Recap

- The patient History has a structure and purpose
- Identify the patient concern & their interpretation of the concern
- Note past medical history, signs and symptoms as well as family history
- To develop a working diagnosis determine if the patient has a traumatic, overuse or insidious onset injury
- Determine if the patient is concerned with pain, weakness, instability or restricted movement

BREAK

15 MINUTES

Hypothesis: Working Diagnosis

A Joint is a Joint

- Joint Regions contain
  - Bone
  - Ligament
  - Capsule
  - Cartilage
  - Synovium
  - Surrounding tendons and muscles
  - Associated bursae
  - Blood vessels
  - Nerves
  - Fat
  - Skin
- Weight bearing & Non-weight bearing

Science is a way of thinking much more than it is a body of knowledge.

Carl Sagan

Compression, Stretch or Infection

- Compression
  - Fracture of bones
  - Neural dysfunction of nerves
- Stretch
  - Tendon/muscle, Ligament/capsule, neural/vascular, bone/epiphyseal
  - Minor damage to full rupture
- Infection or Cancer
- Rheumatoid or Seronegative arthritides

How the structures can be affected

- Bone
  - Tumor, primary, metastatic
  - Osteochondritis
  - Fracture
  - Osteopenia
  - Osteomyelitis

How the structures can be affected

- Soft Tissue
  - Muscle
    - Strain or rupture
    - Trigger points
    - Atrophy
    - Myositis ossificans
    - Muscular dystrophy
  - Tendon
    - Tendinitis
    - Tendinosis
    - Rupture

How the structures can be affected

- Soft Tissue cont.
  - Ligament
    - Sprain or rupture
  - Bursa
    - Bursitis
  - Fascia
    - Myofascitis
  - Joint
    - Arthritis
    - Subluxation
    - Infection
    - Joint mice
    - dislocation

Injuries of the Ligaments and Muscles

- Ligament or Capsular injury
  - Macro or Micro trauma
- Muscle Injury
  - Stretch or Contracture
  - Muscles will contract to protect the joint
  - Contraction injuries
    - Concentric
      - Lifting a heavy load
      - As the mm is contracting
    - Eccentric
      - Overuse injuries
      - As the mm is lengthening

Injuries of the Tendons

- Paratenonitis/Tenosynovitis
  - Edema, local tenderness, warmth, crepitation along the tendon
  - Inflammation of the paratendon (lined by synovium or not)
- Tendinitis/Tendon strain or tear
  - Acute (< 2 weeks), Subacute (4-6 weeks), Chronic (> 6 weeks)
  - Purely inflammatory w acute hemorrhage & tearing
  - Inflammation in addition to pre-existing degeneration
  - Calcification & tendinosis that is chronic
  - Paratenonitis with Tendinosis
    - Palpable tendon nodule w accompanying s/s of inflammation

Injuries of the Bursae

- Bursae are protective cushions placed strategically at points of friction (between muscle/tendon & bone)
- Bursae may be deep or superficial
- Bursitis may be secondary to other ST involvement

The Patient Record

- Order is imperative
- Will future Dr. Massa be bale to understand what present Dr. Massa was thinking? Will anyone else?
- Keep your notes organized
  - List conditions in chronological order with details
  - Use specific headings, asterisks, underlining, etc.

The Patient Record

- Record ALL the data
  - Positives and Negatives
  - This is the foundation of your diagnosis
- Describe pertinent Negatives
  - Ex: Bruising – What would be pertinent negatives to include in the pt. record?
- Data not recorded is data lost
  - If you didn't do it – record that you did not
  - If you did it – record what happened
  - You never know when you may have to go back to your initial exam based on a S/S that comes up later on throughout the course of care

The Patient Record

- Describe what you observed not what you did
  - Incidental findings are still findings
- Best Practices
  - Block time in between patients to complete the patient record
  - Do not leave for the day or begin a new day without completing your patient records
  - What did you have for lunch last Tuesday? If you can't remember that then how do you expect to remember what happened in patient Smith's exam from last Tuesday…

Problems List

- Active
  - Need attention now
  - Need further observation or future attention
  - Warn against possible interaction or injury
- Inactive
  - Keep in the patient record

Good doctors
understand responsibility
better than privilege
and practice accountability
better than business.

Recap

- Many structures are involved in a joint injury
- Determine if there is a compression injury , stretch injury or infection
- Best practices involve impeccable record keeping

BREAK

10 MINUTES

Testing your hypothesis: Examination

Numbness, Tingling & Pain

- History
  - Localize to a specific body region or multiple areas
  - Determine associated s/s such as pain or weakness
  - Onset: abrupt or gradual; due to trauma?
  - Known co-morbidities i.e. diabetes, alcoholism, liver/renal disease, anxiety/depression, drug history
  - Chronic nociceptive v chronic central pain

Numbness, Tingling & Pain

- Exam
  - Sensory
    - Test beginning distally (If not found distally; probably not be found proximally)
    - Pain – Temperature – Light touch – Vibration
  - Proprioception
    - Position Sense
  - Motor testing (Nerve root v Peripheral Nerve)

Numbness, Tingling & Pain

- Nerve Root
  - History
    - Neck pain w upper extremity numbness or Low Back pain w lower extremity numbness
  - Exam
    - Decreased DTR
    - Weakness in corresponding myotome
    - Hypoesthesia in corresponding dermatomal pattern

Numbness, Tingling & Pain

- Peripheral Nerve
  - History
    - overuse or direct trauma
  - Exam
    - Weakness of corresponding muscle
    - Hypoesthesia of corresponding nerve patch on skin

Numbness, Tingling & Pain

- Nerve Plexus
  - History
    - Traction, trauma or tumor
    - Diffuse
  - Exam
    - Pressure on the neurovascular elements reproduce s/s
    - Ex: TOS

Numbness, Tingling & Pain

- CNS including Spinal Cord
  - History
    - Involvement is bilateral
    - May affect temperature
    - Patchy involvement may indicate MS
  - Exam
    - Motor findings → Spinal Cord involvement

Headache

- History
  - Is there a secondary cause? (trauma, metabolic dx, drugs/toxins, infx, intracranial pathology)
  - Triggers or patterns to the headache
  - Primary Headache Categories
    - Migraine
    - Cervico-genic/Tension type
    - Cluster

Headache

- Vascular/Neurologic
  - Decreased blood to the brain (atherosclerosis) Icreased pressure on vasculature (vasodilation or hypertension)
    - Migraine or Cluster
- Tension type/Cervicogenic
  - Direct pull on periosteum, muscle spasm, referred pain or nn entrapment
    - Hx of WAD, suboccipital or bandlike, worse in afternoon, stress related, responsive to OTC

Headache

- Metabolic/Toxic
  - Decreased Glucose to the brain (diabetes, hypoglycemia) Increased metabolism (hyperthyroidism), drug toxicity
    - Hx of hyper/hypo thyroidism, diabetes, anemia, COPD
    - Pt taking medications
    - Relationship to certain foods
    - Occupational exposure
- Miscellaneous
  - Sinus, Eye-strain, CSF pressure changes
    - Hx of spinal tap (CSF pressure)
    - Worse w bending forward or upper respiratory infx (sinus)
    - Assoc w exercise (hydration, BP, mm strain)
    - Eyesight normal orr corrected (eye strain)

Headache

- Migraine with Aura
  - History
    - 30 min – 2 hours aura of scotoma or flashing lights
    - Aura can be as severe as temporary hemiparesis
    - Pulsatile, unilateral (temporal & orbital)
    - Severe
    - F adolescent or pre/post menopausal
    - Insidious (no aura)
    - Lasts for hours (occasionally days)
    - Associated nausea, vomiting, photophobia
  - Exam
    - During aura CN exam positive for sensory or motor deficits
    - Non-specific pain/tenderness (may also be over cervical spine

Headache

- Migraine without Aura
  - History
    - Pulsatile, unilateral (temporal & orbital)
    - Severe
    - F adolescent or pre/post menopausal
    - Insidious (no aura)
    - Lasts for days
    - Associated vomiting
  - Exam
    - Non-specific pain/tenderness (may also be over cervical spine)

Headache

- Episodic Tension type
  - When no Neurological findings apparent & cannot be ties to cervical spine
  - History
    - Any age, insidious
    - At the end of the day
    - Sub-occipital, bandlike over temporal area
    - Hours to days
    - Mild, No nausea & responsive to OTC
  - Exam
    - Non-specific pain/tenderness (may also be over cervical spine)
- Cervicogenic
  - Evidence of arthrosis on x-ray
  - Positive orthos & restricted ROM w certain movements

Headache

- Cluster
  - History
    - 30-40 male
    - Severe, unilateral, happening at the same time daily
    - 45 mins-2 hours
  - Exam
    - Localized non specific tenderness
    - Neuro during attach positive Horner's syndrome (drooping upper eyelid, uneven pupil)

Cervical Spine – Working Diagnosis & Examination

- Segmental Dysfunction
  - History
    - Nonspecific
    - Can be primary dx if patient is asymptomatic
  - Exam findings
    - Local tenderness & subluxation
    - O/N negative
    - AROM variable restriction, PROM endrange restriction

Cervical Spine – Working Diagnosis & Examination

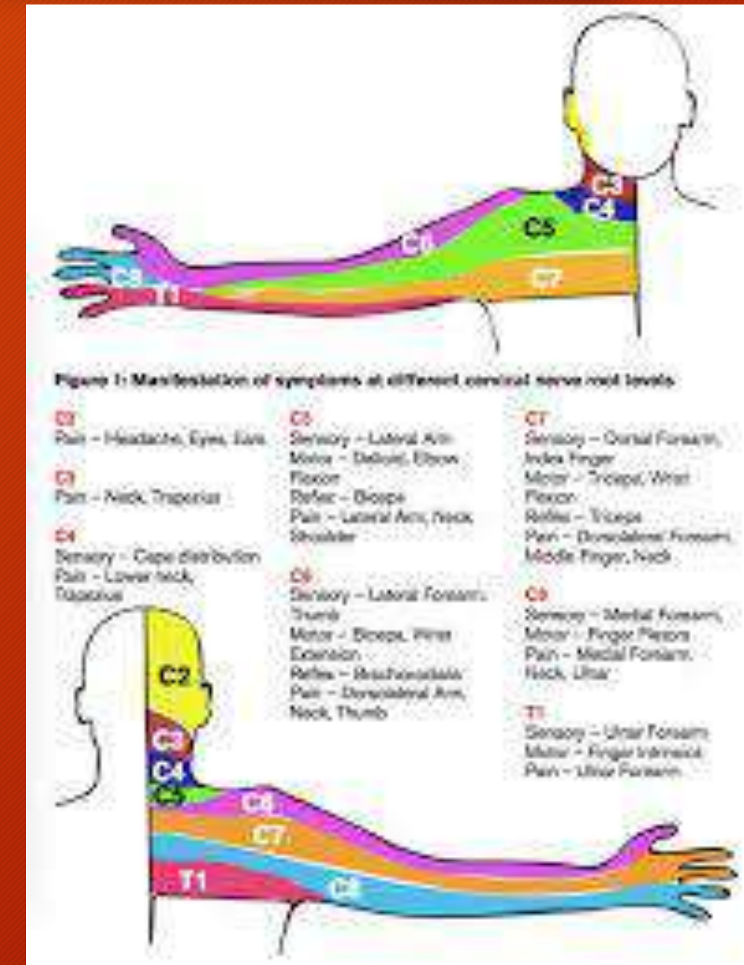
- Cervical Sprain/Strain
  - History
    - acute trauma
    - radiation or referral
    - Valsalva negative
    - worse w specific ROM
  - Exam findings
    - O/N negative
    - AROM pain that contracts involved mm, PROM pain on endrange of involved mm or ligament

Cervical Spine – Working Diagnosis & Examination

- Neuritis or Radiculitis
  - Disc
    - History
      - major or minor trauma
      - previous episodes
      - radiation into arm or hand
      - possible Valsalva
      - if disc protrusion ROM may be painful
    - Exam findings
      - Ortho nerve compression and/or stretch positive
      - deficit in DTR/dermatome/myotome
      - AROM & PROM variable

Cervical Spine – Working Diagnosis & Examination

- Neuritis or Radiculitis
  - Nonspecific
    - History
      - trauma variable
      - may radiate down shoulder & arm
      - Valsalva negative
      - pain w ROM variable
    - Exam findings
      - Ortho nerve compression and/or stretch pos
      - deficit in DTR/dermatome/myotome
      - AROM & PROM variable

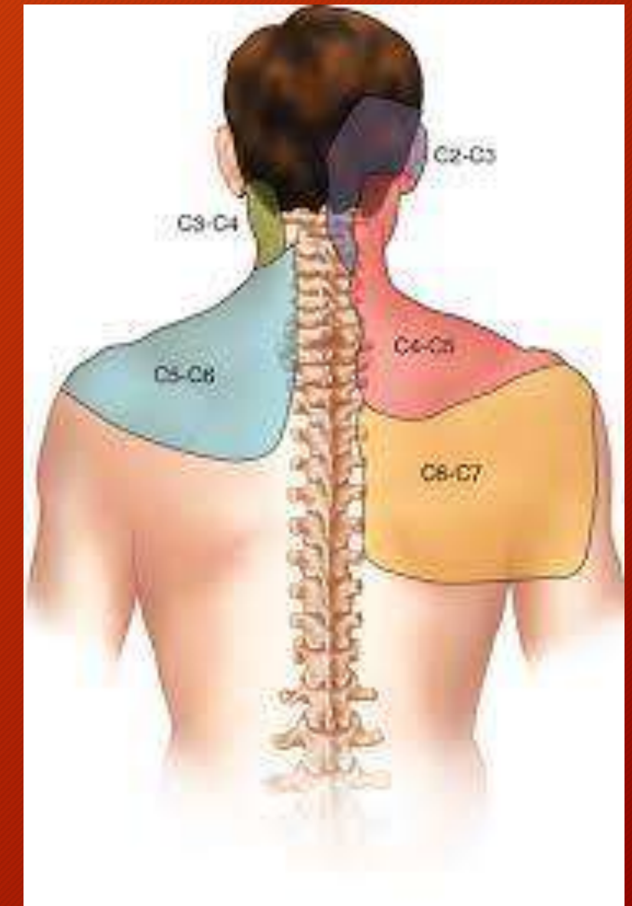


Cervical Spine – Working Diagnosis & Examination

- Cervico-brachial Syndrome
  - History
    - trauma variable
    - possible radiation to shoulder & arm
    - Valsalva negative
    - possible pain w ROM
  - Exam findings
    - Ortho nn compression & stretch tests negative
    - Neuro negative
    - AROM & PROM variable

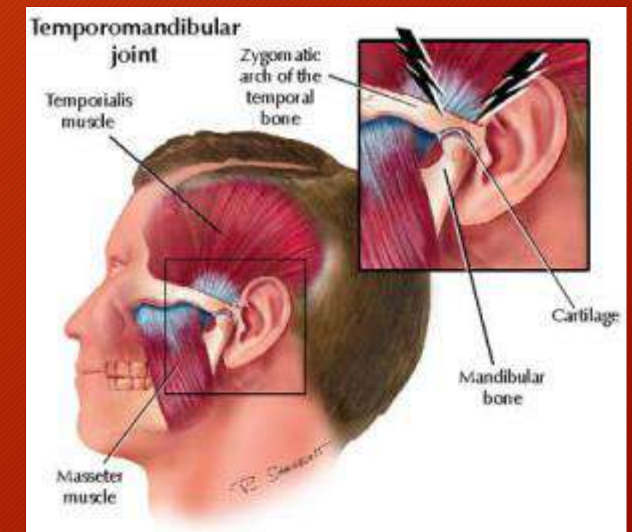
Cervical Spine – Working Diagnosis & Examination

- Facet Syndrome
  - History
    - trauma variable
    - radiation into shoulder/arm to hand/upper back
    - Valsalva variable
    - pain w hyperextension & rotation
  - Exam findings
    - Ortho positive w hyperextension & rotation
    - Neuro negative
    - AROM & PROM variable
    - Mo Palp endrange restriction to side of involved facet



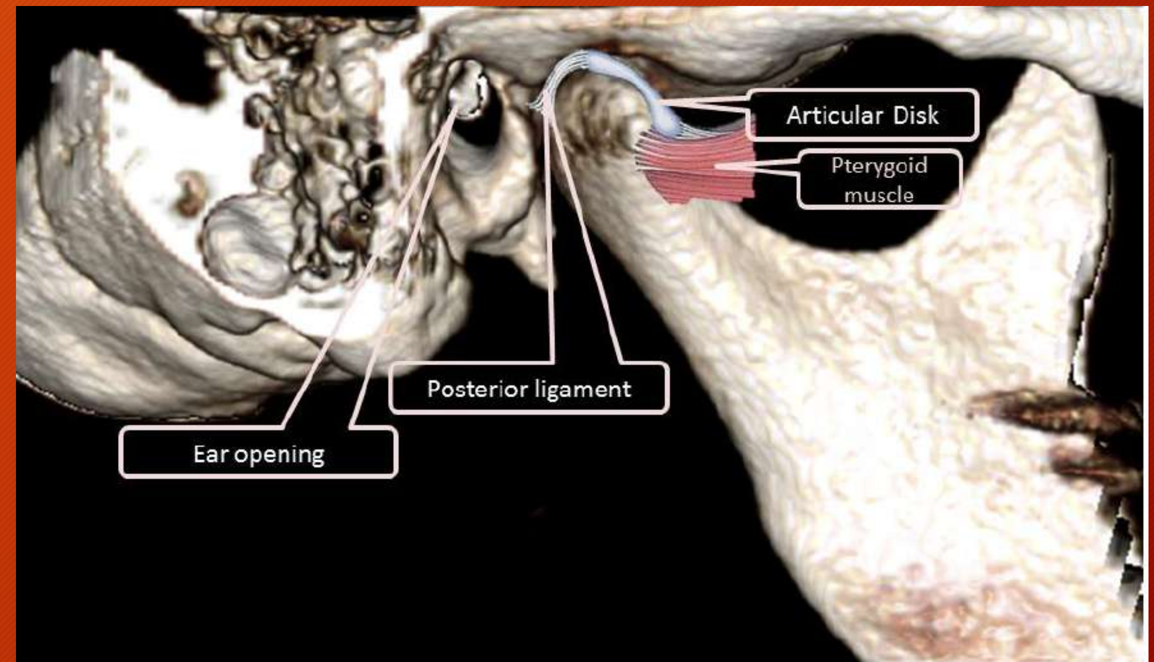
TMJ – Working Diagnosis & Examination

- Capsulitis
  - History
    - pain & tenderness w protrusion or lateral movement
    - Pain w chewing on opposite side or opening mouth widely
  - Exam
    - pain w lateral deviation & pushing mandible forward w mouth open
- Synovitis
  - History
    - pain that is worse w full closure on the ipsilateral side
  - Exam
    - lateral deviation w mandible in rest position
    - pain w condylar compression
    - tenderness at posterior joint near the external auditory meatus



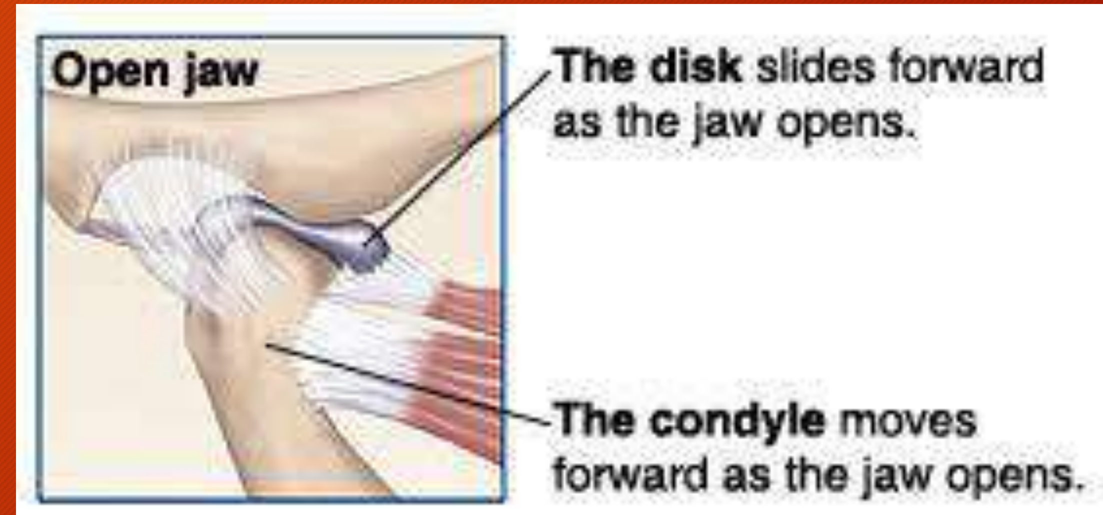
TMJ – Working Diagnosis & Examination

- Disc Derangement w Reduction
  - History
    - Popping or clicking upon opening and/or closing
  - Exam
    - Articular disc is displaced ant or ant-med. The condylar head rests posterior to the disc
    - Opening click: the condyle is translating to it's normal position
    - Closing click: weakness of posterior ligament the disc is not pulled back the condyle slips posterior (behind the disc)



TMJ – Working Diagnosis & Examination

- Closed Lock
  - History
    - Pain & difficulty opening the mouth fully
    - Tenderness. History of clicking
  - Exam
    - Inability to place 2 knuckles in between the front teeth
    - Tender. No popping on opening
- Acute Open Lock
  - History
    - Acute locking in open position
    - History of trauma or past occurrence
  - Exam
    - Apprehensive and unable to close mouth
    - Condyle is dislocated
    - Trauma -> x-ray



Thoracic Spine Working Diagnosis & Examination

- Scheuermann's Disease
  - History
    - M/F 13-17 yo
    - Mid back pain & fatigue
    - Increased kyphosis
  - Exam
    - X-ray findings: ant. VB wedging, Schmorl's nodes, decreased disc height over 3 continuous vertebrae
- Compression Fracture
  - History
    - Older – sudden pain after sneezing or stepping off a step
    - Younger – hyperflexion injury or fall unto buttocks
  - Exam
    - Pain on percussion and deep pressure
    - X-RAY BEFORE ADJUSTING *Fracture may be unstable

Thoracic Spine Working Diagnosis & Examination

- T4 Syndrome
  - History
  - Exam
- Postural Syndrome
  - History
    - Achy & made worse with certain static postures
  - Exam
    - Hyperkyphosis
    - Trigger points in traps (upper, middle lower), levator scap, rhomboids, pecs,

Thoracic Spine Working Diagnosis & Examination

- Herpes Zoster
  - History
    - Burning pain over chest and/or back
    - Skin lesion may be present or not
  - Exam
    - Reddening or vesicles
    - If a dermatome is affected, may appear patchy
- Scoliosis
  - History
    - Back pain with visual findings
  - Exam
    - X-rays reveal: hemivertebra
    - No x-ray evidence: look for associated muscle involvement

Lumbopelvic Working Diagnosis & Examination

- Neuritis or Radiculitis
  - Disc
    - History
      - Trauma or previous episodes
      - Radiation down leg to foot
      - Valsalva may be positive
      - ROM pain variable due to disc protrusion
    - Exam
      - Ortho positive nn stretch (SLR, WLR)
      - Neuro positive DTR, myotome, dermatome
      - AROM variable w weakness; PROM possible
      - Need special imaging for dx

Lumbopelvic Working Diagnosis & Examination

- Neuritis or Radiculitis
  - Unspecified
    - History
      - Trauma variable
      - Radiation down leg to foot
      - Valsalva may be positive
      - ROM pain variable
    - Exam
      - Ortho positive nn stretch (SLR, WLR)
      - Neuro positive DTR, myotome, dermatome
      - AROM variable w weakness; PROM possible
      - Used for unspecified nn root clearly involved

Lumbopelvic Working Diagnosis & Examination

- Facet Syndrome
  - History
    - LBP increased w hyperextension
    - Local pain or referred down leg
    - Trauma variable
    - Valsalva may be painful
    - Worse e specific ROM – hyperextension increases local or radiating pain
  - Exam
    - Ortho positive Kemps or hyperextension
    - Neuro none
    - AROM & PROM variable
    - Mo Palp endrange restriction to side of involved facet

Lumbopelvic Working Diagnosis & Examination

- Spondylolisthesis
  - History
    - Younger = isthmic
    - Older = degenerative (may mimic stenosis)
    - Asymptomatic or LBP with extension
  - Exam
    - Pain with 1-legged balance test
    - X-ray dx from lateral film (grades 1-4)

Lumbopelvic Working Diagnosis & Examination

- LS or SI Sprain & Subluxation
  - History
    - Acute or traumatic overstretch or overcontraction
    - Possible referral of pain
    - Valsalva negative
    - ROM painful w contraction of involved mm
  - Exam
    - O/N neg
    - AROM pain w contracted involved mm
    - PROM pain at endrange stretch of involved mm or ligament
- Piriformis Syndrome
  - History
    - Buttock & posterior leg pain in absence of trauma
  - Exam
    - Pain w resisted ext rotation of hip OR passive medial rotation
    - Referred pain upon palpation of piriformis mm

Lumbopelvic Working Diagnosis & Examination

- Ankylosis or Instability of SI or LS jionts
  - History
    - Chronic instability or Sprain/Strain
    - Repetitive postural stresses
    - Trauma or repeated occurrences
    - Radiation none
    - Valsalva negative
  - Exam
    - Supported Adam's or Belt's positive
    - Neuro none
    - AROM & PROM variable
    - Mo palp Hypermobility

Lumbopelvic Working Diagnosis & Examination

- Ankylosing Spondylitis
  - History
    - Young man w chronic LBP & stiffness
    - Occasional radiation to buttocks, anterior or posterior thighs
    - Stiffness upon rising
    - Relief w activity
  - Exam
    - Global decrease in lumbopelvic ROM
    - X-ray dx: pseudowidening of SI joints, erosions & sclerosis, squaring of VB, calcification of annulus fibrosis & spinal ligaments
    - Lab tests are helpful but not diagnositic

Recap

- It is important to have a systemized approach to History, working diagnosis & examination
- Localizing s/s to predictable working diagnosis saves time during the exam
- Be flexible in your findings and record EVERYTHING in case you need to come back to them
- People aren’t textbook

BREAK

10 MINUTES

The Wellness Patient

The Wellness Patient - Intake

- Whether the patient is coming in solely for wellness care (asymptomatic) or they have just completed acute or corrective care, a wellness intake ushers the patient into a new phase of care.
- This is a familiar process just as they have already experienced in their previous intake (for acute or corrective care)
- If they are asymptomatic, there should still be some sort of intake process, it’s just that the emphasis during the intake is shifted.

The Wellness Patient – Review of Systems

- Review of Systems
  - A thorough Review of Systems exploring past and/or current infection, injury or illness is essential to educating the patient on the effectiveness of chiropractic & wellness care
- Wellness Assessment
  - All components of lifestyle wellness behaviors along with height & weight (CA law)
  - Optional: body composition, functional health (previously referred to as functional medicine) systems screening

Review of Systems

- It is your professional and ethical responsibility as a doctor to ask and follow up on a patient's Review of Systems
- GASTROINTESTINAL
- RESPIRATORY
- EYES, EARS, NOSE, THROAT
- ENDOCRINE
- NEUROLOGICAL
- CARDIOVASCULAR
- REPRODUCTIVE
- URINARY
- MUSCULOSKELETAL
- SKIN

Review of Systems cont.

- SOCIAL HX
- OCCUPATIONAL HX
- FAMILY HX – “BIG 5” (Cancer, CV, Psych, Autoimmune, Ortho/Neuro)

- SURGERIES
- HOSPITILIZATIONS
- ILLNESSES CHILDHOOD OR ADULT /IMMUNIZATIONS
- TRAUMAS
- ALLERGIES / HEMATOLOGICAL / LYMPHATIC

Wellness Questionnaire

- When a patient is asymptomatic, there is still much improvement that can be made in the individual’s overall health
- A wellness questionnaire can help to identify areas of improvement

Wellness Questionnaire cont.

- Components of a Wellness Questionnaire
  - Salutogenesis or general state of wellbeing
  - Outlook and Attitude
  - Stress levels
  - Work ergonomics and contentment
  - Hobbies
  - Psychosocial health

Wellness Questionnaire cont.

- Diet & Nutrition
  - Special diet
  - Food allergies/sensitivities
  - Fast food/Meals eaten out
  - Servings of fruits/vegetables
  - Servings of water
- Alcohol/Tobacco/Caffeine
- Exercise & Activity
  - Type, frequency, duration
- Sleep
  - Adrenal function

The Wellness Patient - Exam

- Components of a Wellness Intake Exam
  - The Basics
    - Height, Weight, Blood pressure
    - Optional: Body composition
  - Posture Screening
    - Although a patient is asymptomatic, we know that postural corrections decrease spinal cord pressure allowing for better overall brain function
  - Palpation Exam
    - Along with asymptomatic postural findings, there may also be asymptomatic subluxation and associated muscle palpation findings that correlate to Upper Cross Syndrome, Lower Cross Syndrome and/or kinetic chain dysfunction

The Wellness Patient - Exam

- Functional Screening Exam
  - Assessment of functional movement, Balance, Fall risk
- Additional Objective Measures
  - Thermography
  - Technique based Radiographs
  - Blood, Urine and/or Stool labs
- Ancillary Tests
  - Technique based assessments for subluxation
  - Underlying causes

Wellness ROF

- Explain chiropractic in relation to expression of optimal health
- Explain how chiropractic influences the brain
    - Physical health
    - Emotional health
    - Mental health and cognitive functioning

Wellness ROF

- Talk about the 3 causes of subluxation
  - Most people relate chiropractic to the physical cause of subluxation, but when a person is asymptomatic, this is irrelevant to them. Why come back if they are no longer in pain?
  - Nutrition & Stress influence the chemical causes of subluxation and proactively preventing these causes improves overall health
  - Stress and deleterious health habits influence emotional causes of subluxation and proactively preventing these causes improves overall health
- Set Wellness Goals and engage the patient in a partnership towards improvement.

Wellness Re-evaluation & Re-eval ROF

- Wellness Re-exam should closely mimic the Wellness Intake
- Wellness Re-eval ROF
  - Celebrate the wins – remind the patient of the goals set at the intake and report back the positive changes made
    - These can be found in your SOAP notes – Keep good notes!
    - Focus on behaviors but celebrate objective findings such as weight lost, medication dose reductions, postural changes, etc.
    - Set new goals and keep the momentum going!

A Culture of Continual Improvement

- The common theme in chiropractic practices is that once a patient completes acute or corrective care, they transition into wellness care.
- Wellness care typically consists of the patient coming in on a regular basis for adjustments and the DC talks about chiropractic.
- There is not structure to this and after about a year or so, the patient will move on.
- The magic is lost because in the beginning there was a goal; an end-point. Now, they just come in with nothing to look forward to or strive for.

A Culture of Continual Improvement

- In creating a Wellness Protocol, you are better able to guide the patient.
- You are providing measurable objectives and goals
- You are creating a sense of empowerment as well as providing accountability
- You are shifting the focus of what it means to be well and thriving away from the absence of pain and discomfort

Conclusion

Today's Take-aways

- Whether you are a MS specialist or a Wellness Doctor you are first and foremost a DOCTOR of chiropractic
- It is a privilege and honor to be a doctor
- If you are an excellent doctor you don't need to be good at sales or marketing
- Build the Chiropractic Practice of your dreams 1 person at a time and help spread the Big Idea!
- Go forth to do, to give, to love to serve!

Keep in Touch

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