Chiropractic Documentation; The Subjective Element

By
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Subjective

- As stated before, the subjective element of chiropractic documentation relates to what the patient tells the doctor.
- This information can be either in the form of a completed history form or verbally during a face-to-face consultation with the doctor.
- The information that should be collected for the subjective element includes:

Initial History

- **Chief Complaint (CC)** – This would be the symptoms or condition causing the patient to seek treatment. This could be an acute or a chronic injury or illness or it could be related to a malformed body member. In most of healthcare the lack of a chief complaint would indicate that no care is necessary. Definitely third party payers would find that the lack of a chief complaint would cause the care to not be medically necessary. However the chiropractor may find that care would be clinically indicated for a patient without a chief complaint in order to prevent or delay the recurrence of a condition that is currently dormant. The chief complaint is an element that the doctor would definitely want in the patient's records.
- **History of Present Illness (HPI)** – The HPI contains details of the chief complaint. This will include a chronological description patient's condition starting from onset to present. The HPI is one of those elements that the doctor would definitely want in the patient's records.
- The HPI includes:
    - Location (and radiation) – You should note the location of the chief complaint and any radiation of pain or numbness that the patient may be experiencing.
    - Quality (and character) – This is the patient's description of the pain. You can ask the patient open-ended questions (such as Can you describe the pain for me?) or leading questions offering the patient multiple options. It is important to note that specific descriptors relate directly to specific source tissue. See the table 1 below:

Table 1 **Description of Pain and Structures Related to the Pain**

Pain Description	**Related Structure**
Cramping, Dull, Aching	Muscle
Sharp, Shooting	Nerve Root
Sharp, Bright, Lighteninglike	Nerve
Burning, Pressurelike, Stinging, Aching	Sympathetic Nerve
Deep, Nagging, Dull	Bone
Sharp, Severe, Intolerable	Fracture
Throbbing, Diffuse	Vasculature

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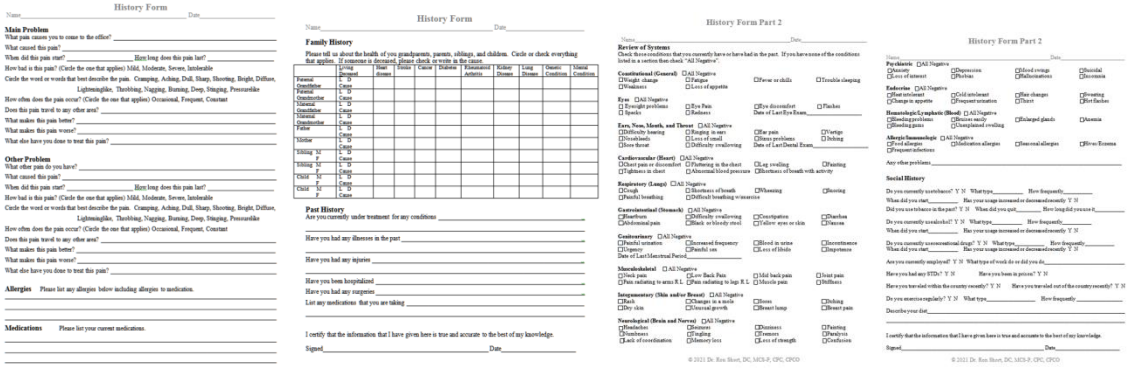
  - Severity – Severity is usually measured with the numeric (0 to 10) pain scale. The 0 level equates to no pain and the 10 level equates to the worst pain imaginable (giving birth, kidney stone, or having an arm ripped off by an alien). You can also use the terms mild, moderate, and severe. Mild would equate to a level of 0 to 3, moderate would equate to a level of 4 to 7, and severe would equate to 8 and over. You can include the term intolerable for the highest level of pain.
  - Onset and duration - The onset is basically when this condition started. The duration is now long has this condition affected the patient. Be sure to determine if this is the first time this condition has occurred or has it happened before.
  - Timing - The timing relates to the frequency of the pain. How often during the average day is this condition affecting the patient. This is best expressed by using;
    - Occasional 0% - 33%
    - Frequent 34% - 66%
    - Constant 64% - 100%
  - Context (mechanism of trauma) – The context or mechanism of trauma directly relates to how this condition occurred. The use of the term "mechanism of trauma" can be misleading. It is not required that a trauma occurs. The condition can onset slowly over a period of time or suddenly with no obvious cause.
  - Modifying factors (Aggravating or relieving factors) – Essentially this is a notation describing what makes the condition worse and what makes it better.
  - Associated signs and symptoms – These are other signs and/or symptoms that manifested at or close to the same time as the chief complaint. They may be related to the chief complaint or they may indicate a previously silent condition that warrants investigation.
  - Prior interventions, treatments, medications, secondary complaints – What has the patient done prior to presenting at your office to relieve the pain. For example; if the patient spent the three days following the onset of the condition sitting on a heating pad then you know that swelling and delayed healing may be a concern.
- **Review of Systems (ROS)** – The review of systems is an inventory of body systems obtained by asking a series of questions to identify signs and/or symptoms that the patient may be experiencing.
- The ROS is very important in determining secondary complaints.
- The ROS element is where the doctor may want to be selective in what they ask.
- The chiropractor would definitely want to inquire into the constitutional, musculoskeletal, and neurological systems; however inquiry into other systems would be at the discretion of the doctor.
- The systems that are surveyed for this purpose are:
  - Constitutional Symptoms (e.g. fever, weight loss)
  - Eyes
  - Ears, Nose, Mouth, and Throat
  - Cardiovascular
  - Respiratory

  - Gastrointestinal
  - Genitourinary
  - Musculoskeletal
  - Integumentary (skin and/or breast)
  - Neurological
  - Psychiatric
  - Endocrine
  - Hematologic/Lymphatic
  - Allergic/Immunologic
- **Past Medical History, Family History, and/or Social History (PFSH)**
- The PFSH consists of a review of three areas:
- Past medical history – The past medical history will provide the chiropractor with information that will prove beneficial assessing the patient's condition and formulating a treatment plan. The past medical history should include notations regarding:
  - Past illnesses including major illnesses and childhood illnesses
  - Serious accidents of any type
  - Hospitalizations for any reason
  - Surgeries of any type including dental
  - Allergies and adverse reactions with special notation regarding allergies and adverse reactions to medications
  - For children 18 and younger there should be notations regarding prenatal care and birth
  - A list of current medications
- Family history – The Family history will prove beneficial to the chiropractor in identifying genetic predispositions that could aid in assessing the patient's condition and formulating a treatment plan. The family history should include:
  - At minimum notations regarding parents, siblings, and children. Notations regarding grandparents could also prove beneficial
  - Notations regarding conditions that exhibit a genetic predisposition. Examples of this would include but not be limited to; heart disease, stroke, diabetes, cancer, kidney disease, lung disease, high blood pressure, mental conditions, and genetic conditions.
  - The cause of death for any deceased family members.
  - Details regarding any identified condition such as age of onset, any complications, etc.
- Social history – The social history will prove beneficial to the chiropractor by identifying past hazardous exposures that the patient may have experienced. These exposures could point to risks that the patient has regarding their current condition and would prove helpful in assessing the patient's current condition and in the development of a treatment plan.
- The social history should include:
  - Notations regarding tobacco use to include what type of tobacco used, how frequently it is used during the day, at what age the patient started using tobacco, if they have increased or decreased

their tobacco usage, and if they have noticed any adverse effects. If the patient used tobacco in the past at what age did they quit?
    - Notations regarding alcohol use to include what type of alcohol is used, how frequently it is used, at what age the patient started using alcohol, if their alcohol usage had increased or decreased and when. If the patient used alcohol in the past at what age did they quit?
    - Notations regarding recreational drug use to include the age at which the patient started using drugs, the type(s) of drugs used, the frequency of drug use and if drug usage has increased or decreased. If the patient has used drugs in the past at what age did they quit?
    - Notations regarding work history and occupation to include current employment status, most recent employers, type of work, type of hazards patient may have been exposed to, and any past work related injuries.
    - Notations regarding past sexual behavior primarily focused on identifying high risk behavior. Approach this subject delicately and don't push if the patient exhibits reluctance.
    - Notations regarding past prison experience primarily focused on identifying any exposure to hazardous material or diseases.
    - Notations regarding past travel experience primarily focused on recent travel to high risk regions.
    - Notations regarding exercise to include type of exercise and frequency of exercise.
    - Notations regarding the patient's diet primarily focused on quality and quantity of food eaten in an average day.
- These questions should be put into a form that can be completed by the patient when they initially present at your office.
- The questions should be in patient friendly language so that the patient understands the questions being asked of them.
- The history informs your consultation and your exam.
- It identifies areas to be investigated in more detail while talking to the patient during your consultation.
- For example; if the patient indicates on the history form that they have moderate pain the consultation is where you have them put a number to the pain based on the numeric pain scale.
- Have your assistant watch the patient while they are completing the history form.
- If the patient seems to be having problems with the form then the assistant should offer to assist the patient, even going so far as to read the questions to the patient and filling in their answers.
- It should be noted in the documentation that the patient was assisted with the history.
- The sample history forms shown here are divided into two parts.
- The first part contains the chief complaint, the history of present illness, the family history and the past medical history.
- The second part contains the review of systems and the social history.
- The first part can be used by itself for Medicare patients as it covers all areas required by Medicare.
- However I would recommend that you use both parts with all patients as this will provide valuable information with which to evaluate the patient, simplify office procedures, and provide consistent documentation.

- These sample history forms are available in my book *Chiropractic Documentation.*



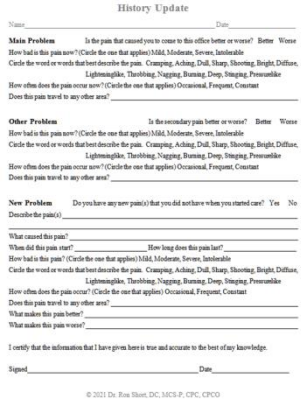
Initial Consultation

- You cannot rely on the history form alone to provide you with the details that you need regarding the patient's condition.
- Therefore you need to sit down face-to-face with the patient and review the key points of the history with them.
- Many times patients will omit information that you will find useful because they think that it is trivial.
- The consultation is your chance to more deeply probe into the details of your patient's condition.
- Review the history form before the consultation and note those items that need clarification or more detail.
- Be sure to cover the chief complaint and history of present illness in the consultation.
- This is also the point where a patient may discuss a problem that they weren't comfortable committing to paper.
- The consultation is also the time when the patient decides to trust you or not.
- Don't rush the consultation.
- Take the time necessary without making the patient feel that they are keeping you form something else.
- This will cause the patient to feel comfortable enough to open up about details that they otherwise might not reveal.

The Re-examination

- The subjective element of the re-exam will primarily focus on the chief complaint and the history of present illness.
- These two parts will give you a good interpretation of the patient's view of their condition after the previous round of treatment visits.
- There may occasionally be a notation for the past medical history, social history, or family history but these will be limited and may or may not impact the current course of care.
- You should definitely ask if anything has changed in those areas.

- The subjective portion of the re-exam should answer the following questions:
    - Does the patient still have the condition that they presented to the office?
    - Has this condition improved from the patient's point of view?
    - Is the patient experiencing any new problem(s)?
    - Is the patient experiencing any new symptoms different from the existing problem?
- The answers to these questions can be used to determine if the patient has reached maximum medical improvement or if further care is necessary.
- This sample history update form is available in my book *Chiropractic Documentation.*



History Update

Name_____ Date_____

Main Problem Is the pain that caused you to come to this office better or worse? Better Worse
How bad is this pain now? (Circle the one that applies) Mild, Moderate, Severe, Intolerable
Circle the word or words that best describe the pain. Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lightninglike, Throbbing, Nagging, Burning, Deep, Stinging, Pressurelike
How often does the pain occur now? (Circle the one that applies) Occasional, Frequent, Constant
Does this pain travel to any other area? _____

Other Problem Is the secondary pain better or worse? Better Worse
How bad is this pain now? (Circle the one that applies) Mild, Moderate, Severe, Intolerable
Circle the word or words that best describe the pain. Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lightninglike, Throbbing, Nagging, Burning, Deep, Stinging, Pressurelike
How often does the pain occur now? (Circle the one that applies) Occasional, Frequent, Constant
Does this pain travel to any other area? _____

New Problem Do you have any new pain(s) that you did not have when you started care? Yes No
Describe the pain(s) _____
_____
What caused this pain? _____
When did this pain start? _____ How long does this pain last? _____
How bad is this pain? (Circle the one that applies) Mild, Moderate, Severe, Intolerable
Circle the word or words that best describe the pain. Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lightninglike, Throbbing, Nagging, Burning, Deep, Stinging, Pressurelike
How often does the pain occur? (Circle the one that applies) Occasional, Frequent, Constant
Does this pain travel to any other area? _____
What makes this pain better? _____
What makes this pain worse? _____

I certify that the information that I have given here is true and accurate to the best of my knowledge.

Signed_____ Date_____

Medicare

- Medicare requires a history of present illness, a past medical history, and a family history if it is relevant.
- It does not require a social history or a review of systems.
- Even though these elements are not required I would perform them anyway as they may point to secondary problems or hidden conditions.

Summary

- The subjective element of your documentation is where you get to know the patient and find out what they think about their condition and how it is affecting them.
- Be thorough and cover all relevant areas.