**NARRATIVE CREATION CHECKLIST**

**Please complete this checklist and attach it to the top your submission package**

**Scan and email file to:**

**dr.michael@academyofchiropractic.com**

**Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M / F Age\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_DOA:\_\_\_\_\_\_\_\_\_\_\_\_**

**Circle Y if enclosed or N if not:**

**Y N Patient's initial written intake/history form**

**Y N Initial evaluation: Dated \_\_\_\_\_\_\_\_\_\_\_ EHR FORMAT only NO Checklists**

**Y N Final evaluation: Dated \_\_\_\_\_\_\_\_\_\_\_\_** **EHR FORMAT only NO Checklists**

**Y N Attorney's Name and address so we can address the report for you**

**Y N Diagnostic reports (MRI, CT scan, X-ray digitization, EMG/NCV, etc)**

**Y N All treating doctors/therapists’ reports (orthopedist, neurologist, physiatrist, etc)**

**Y N Patient's own Functional Loss (personal – social – work statements-FINAL ONLY**

**Y N Executed (signed) HIPAA Chain of Trust Agreement (ONLY ONCE)**

***Do NOT send daily SOAP notes, Re-evaluations, Oswestry or similar forms***

 **Print clearly**

**Dr.'s (name on report) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City and State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dr. Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email to send report: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Total Number of Chiropractic treatments:\_\_\_\_\_\_\_\_\_\_Dates of all Chiropractic evaluations and re-evaluations including:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Total Number of Physical Therapy treatments: \_\_\_\_\_\_\_\_ *DONE BY A LICENSED PT (not Chiro) notes attached? Y N Regions for PT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Gap in Initial Care? Y N (Covid went to another doc, self-medicated, thought it would go away, etc.)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Gap in Care (other) Y N Reason (Covid, went on vacation, death in family, done prior to final evaluation (dates)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Anything else we should know about this case? The more you tell me the better\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TOTAL NUMBER OF PAGES \_\_\_\_\_\_\_\_\_\_\_\_\_ If you can’t scan fax to: (888-977-1893)**