**NARRATIVE CREATION CHECKLIST**

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

**Via fax (888-977-1893) or scan and email to:**

**dr.michael@academyofchiropractic.com**

**Patients Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M / F DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_DOA:\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Y N Patient's initial intake form**

**Y N Initial evaluation: Dated \_\_\_\_\_\_\_\_\_\_\_**

**Y N Final evaluation: Dated \_\_\_\_\_\_\_\_\_\_\_\_**

**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) statement(s)-FINAL**

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Total Number of Physical Therapy treatments:\_\_\_\_\_\_\_\_ *DONE BY A LICENSED PT (not Chiro)***

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

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

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

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

**Anything else we should know about this case? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TOTAL NUMBER OF PAGES \_\_\_\_\_\_\_\_\_\_\_\_\_**