Clinical Record Keeping: FREQUENTLY ASKED QUESTIONS

#1.

Q: What are the essential elements of a good New Patient intake form?

A: The intake form you use with all of your new patients is more than just the first piece of paper that your patient touches. It will become the foundation of their clinical record and, by extension, the care you deliver.

It will have a place for administrative details (patient ID, contacts, office/privacy policies) and subjective facts about the patient's health history (their chief complaint, past problems, family issues, current care and lifestyle habits). You are asking your new patient to document a lot of information. How many pages long should it be? There are no hard and fast rules. Essentially, your intake form should have three features

- User Friendly – The form is well constructed with a professional appearance on high quality paper. The font/type size are easy on the eyes and the layout is spacious; it makes use of different modalities (explain with words, check off boxes on a list, make drawings on a diagram). All of the questions are relevant and clear. It strikes a balance between respect for your patient's time and an appreciation of the patient's need to fully express their situation. And what they need most is to know you 'get' them, so give them a form that facilitates this.
- Educational – You can include features on the IF which serve to educate both the patient and you. A customized header - advertising who you are, what you do, how well-educated you are and lists any special skills or interests you have - is more effective than one which just gives your clinic address and contact numbers. On the checklists of conditions, along with the red flag ones, you can include disorders that you want the patient to know you treat. When you include a space for them to indicate who referred them you can discover potential networking connections for inter-professional collaboration. With the appropriate question you can also learn how they found you, which will reveal the advertising platforms that are most useful.
- Provides an Answer To the Question "Should you take on this patient's case?" It is critical that you gather enough information at the first visit to be confident that you will not cause harm. The IF should give you some insight into the nature of their situation and help you to decide if you are optimistic that you can help them.

A well-designed new patient intake form will improve your consistency and efficiency in spotting both red flags and opportunities for building your practice.

#2.

Q: What are Patient Based Outcomes Assessment Instruments and when should they be used?

A: PBOAI's are special Intake Forms (questionnaires) for special patients – people with chronic/severe pain and people who have been injured at work or in a motor vehicle accident. Some practitioners use them with all of their new patients in order to clearly document their progress with care. We can use these 'tools' to assess both a patient's pain and their functional abilities, which are often inextricably linked.

We are all familiar with **Practitioner** Based Outcomes Assessments – objective measurements of strength or posture or active ranges of motion. They are useful to document a patient's baseline facts and how they change over time. Dynamometres, goniometres and plumb lines have been long regarded as the gold standard of evidence of benefit from treatment.

But, what about the patient's subjective experience? How a patient feels and how they are functioning is becoming an equally important measure of a treatment's success. **Patient** Based OAI's give us a way to make the subjective objective. How's this done? Write it down in words, give it a number, make a picture of it, choose statements that best reflect one's position/opinion – these are all strategies that are used to 'measure' and document the facts of a patient's experience.

Patient Based Questionnaires come with many names. You may have heard of the McGill Pain Questionnaire, or the Vernon-Mior Neck Disability Index or Roland-Morris or Oswestry. There are dozens of valid questionnaires available for use in your office. You will want to ensure that the one(s) you choose will be responsive to the effects of treatment.

How are these special intake forms used? There is only one rule. The questionnaire must first be administered before any treatment is given. It is then repeated after a course of care is completed and the results are compared.

Should you use them in your office? They are a great tool to objectively demonstrate the benefits of what you do. Your patients and interested third parties (insurance companies, lawyers, etc.) all want to know that your particular type of treatment actually helps. So do you!

Patient-based assessment questionnaires are an important tool for hands-on health care professionals who want to document the effectiveness of the treatment they provide.

#3

Q: When you document the history of a patient's chief complaint, how much information is 'enough'?

A: Every new patient has their own unique needs and you have some detective work to do. Whether in the patient's hand on the intake form or yours as you conduct a patient interview, you need to record the answers to the many questions you have about the complaint which brings them in. There are important details to be gathered – facts which will establish a baseline and influence your choice of physical examination procedures and your decisions regarding their case.

It is recommended that you make use of a mnemonic device to ensure that ALL the necessary questions about their chief complaint are asked and answered. One popular one is 'SOCRATES' (Site, Onset, Character, Radiations, Associated symptoms, Time course, Exacerbating/Relieving factors, Severity). Another is 'OLDRFICARA' (Onset, Location, Duration, Radiations, Frequency, Intensity, Character, Aggravation, Relief and Associated symptoms).

Make a table with a place for each of the features and fill the blanks as they relate their story to you. This will ensure that you get it all down.

We tend to pay more attention to all of these details when the patient is a brand new patient, but what about the regular patient who comes in with a new complaint? Do you still need to ask all these questions? Yes you do. A 'mini-history' will contain all of the same elements as an initial work-up, so keep your mnemonic ready to go any time a patient complains of something different.

Don't forget one of the most important requirements of a patient's subjective reporting – **be specific**. You could write down that the patient has 'knee pain'. Or you could note that they have 'sharp, intermittent pain localized to the medial aspect of the tibial plateau'. The second version is infinitely more useful.

The history of a chief complaint provides valuable clues to the patient's condition – figuring out both cause and cure depends on your ability to collect and document all of the necessary facts.