ONGOING TREATMENT NOTES:
What to write down when there's nothing to say.

"So, how are you doing today? What can I help you with?"
Every visit starts with some version of this question.

If your patient has a specific complaint, it should be easy to generate enough material for record keeping purposes because you must take a mini-history (SOCRATES or OLDRFICARA), examine the problem area, document your findings, come up with a clinical impression, make note of today's treatment and the plan for further care, as well as any recommendations for self-care or referral to another practitioner.

Your notes can practically write themselves!
But what do you do when they have no complaints? They say they are just there to relax. Their body language makes it obvious they're impatient, ready to jump up on the table and not waste a minute of their scheduled treatment time with your questions or tests.

They want to de-stress. But do they even think about the pressure on their healthcare provider to keep good clinical records? Do they have any idea what it's like to struggle with the lack of notable subject matter or the tediousness of repeatedly writing down the details of a completely unremarkable treatment session?

They just don't know how stressful it can be to produce good notes when a patient is reluctant to cooperate and give you something (or anything) to work with.
Fortunately, there are some tricks of the trade that can help with your record keeping when a regular patient comes in with absolutely nothing to complain about.
And it can even mean writing less, not more!

Remember, the standard in healthcare record keeping uses the 'SOAP' format. If the answers to these questions are documented then the daily notes are rated as 'adequate'.
S – subjective: What did they say?
O – objective: What did you see?
A – assessment: What do you think is going on?
P – plan: What's the treatment? What else can they do (self care/referrals)? What's next?

For those times when there's nothing to say, here are some suggestions around

1. questions to ask
2. physical exam screening tests
3. assessment summaries
4. treatment notes abbreviated

I am also including some sample treatment notes for a regular patient.

General Guidelines:
- make an entry under each of the four headings; be consistent throughout. Eg. if you are (for RK purposes) focusing on a particular area, all entries should relate to this area. Keep it simple.
- be specific with any details. "Knee pain (?)" or "Vague discomfort at the lateral aspect of the knee and proximal calf" The second example is infinitely more useful.
- negative responses are just as significant as positive ones. They document the fact that you queried/checked specific things.
- use abbreviations and the key to your abbreviations more effectively

1. Questions to ask: Some are more appropriate for a regular patient but you haven't seen in a few months, some are more useful for your very regular regulars. You generally want to rule out red flags, assess treatment effectiveness and show interest in their overall health/wellness

- Since your last visit have you had any falls or accidents?
- Since your last visit have there been any changes to your health in general?
- After the last treatment, how have you been doing with (any complaint they had)?
- Have you had any headaches?
- Do you ever notice any weakness or tingling in your arms/hands or legs/feet?
- Are you sleeping well?
- How are your energy levels these days? What about your stress levels?
- Have you noticed any issues with your balance?
- Any digestive disturbances like heartburn or constipation?
- When you first wake up in the morning do you have any stiffness or pain in your feet or hips or hands?
- Do you notice any stiffness in your hips or low back when you get up after sitting for a while?
- How much / what kind of exercise are you doing these days?

2. Tests to do: It's handy if your daily notes 'form' includes diagrams, charts and checklists. There should be a place for all of the things that as hands-on practitioners we are expected to notice - observations, ROM's , palpation, special tests and vital signs

- Posture
- Gait
- General appearance
- Active ROM's - eg. Apley's scratch tests for the shoulder
- Passive ROM's - eg. internal/external rotation of hips, flexion/extension of wrists
- Resisted ROM's – eg. grip strength or foot dorsiflexion
- Palpation findings – bony/soft tissue tender points, hypertonicities
- Sensory screening – eg. compare light touch along arm/leg, right vs left

- Pulse rate, body temperature
- Learn a new test every so often and try it with all your regular patients eg. Allen's test, Trendelenburg, Rhomberg (look them up!)

3. Assessment: Your impression of what is going on today. If you are working from a diagnosis provided by their physician, be sure to include it.

- Part of ongoing treatment plan 3/10
- Chronic postural strain to pelvis/low back with short hip flexors
- Chronic periscapular/shoulder girdle dystonia secondary to desk work
- Recurring cervicogenic tension headaches with chronic postural strain
- Ongoing bilateral calf hypertonicity due to work on feet
- Chronic myofascial trigger points secondary to fibromyalgia
- Ongoing prevention of lateral epicondylitis (or plantar fasciitis)

4. Plan: For documenting the treatment provided today, it is helpful to link the specific details of your treatment to your physical examination findings, so if you can use one method (eg. checklist or diagrams) to indicate both at the same time, you will save yourself some effort.

You can also make copious use of abbreviations and your abbreviations key.
If there are certain things you always do, find a way to create 'protocols'.
For example, you write down SP3. Your key clearly outlines that SP3 is 'Shoulder Protocol number 3' and it consists of ……
This will save you from repeatedly writing down all the exact details.

What else can the patient do (self care, exercises, referrals)?
What's next? Are there any issues you want to explore at the next scheduled visit?

How to generate a chief complaint to hang your clinical notes on:

Patient: "I'm just here to relax"
HCP: "For sure we'll be doing a full body treatment but I just want to know if you notice more tension in your upper body or your lower back and legs? Do you ever have any tingling or numbness in your hands or feet?"
Patient: "No. But it's definitely more my shoulders and upper back"
HCP: "Is it worse on the right or left? Do you notice it more when you wake up, or at the end of a day at the desk?"

These sample notes use lots of abbreviations. You can use standard ones (WNL = within normal limits, TP = tender/trigger point, etc.) and your own, as long as they are defined in the key you have on hand to provide to anyone who will read the notes.

July 6, 2018
S – No cc but C sp/UB mm tension, R>L, inc. by end of day, no rads
O – Mild anterior head carriage, mild bilat shoulder elevation/protraction
Csp ROM WNL, GH joints int/ext rot bilat WNL
Grip strength Normal bilat
Myofascial TP's (UB pattern – see key)
A – Chronic postural strain due to desk work
P - Tx – SP#3, CspP#2 (see key)
Shown pec minor stretch, do 2x daily
Try ball sit. F/U next week

July 13, 2018
S – Last Tx helpful, No cc but inc. stress, tough to fall asleep lately, No HA's
O – Slumpy posture, Csp, Lsp ROM's WNL, Skin tone/temp normal
Soft tissue palpation findings – (label the pattern, see key)
A – General muscle hypertonicity – shoulder/pelvic girdles secondary to stress
P – Tx – Full body massage – SP #1, LBP #2, CspP#1 (see key)
Increase aerobic exercise – min 3x per week
F/U next week

July 20, 2018
S – Slept better all week, gen. less stressed. No cc but started cycle 10 km 4x/week,
Noting some muscle tension in calves/ quads
O – Posture good, Gait normal, A ROM's bilat knees/ ankles WNL, Mild stiff with hip flexion bilat, P ROM int/ext rotation hips WNL , R ROM hip flexion bilat WNL
Palpation – TP's in ant, post and lat compartments of calves, rectus femoris bilat
A – Hypertonicity of lower limb muscles due to increased activity
P – Tx- LLP #2, LBP #1 (see key)
Stretch calves/quads post cycling
F/U next week

TIP: You can slip in questions and tests as you go through the regular treatment. Gait and postural observations can be made as they walk in; checking vitals and comparing Passive ROM's or strength of a body part can be done while they're on the table.

Re-assessments: There comes a time when even the most regular of patients must be reassessed. Schedule the appointment as a 'reassessment' and add some extra time. Ten to fifteen minutes should suffice.
(Whether you charge more for the appointment is up to you and your patient.)

Why? It is required of all licensed healthcare providers.
When? At 'regular' intervals – every six months or annually for patients who are generally well..
How? Refer back to your notes from their first visits (or the notes from their previous reassessment) for comparison. Stick to the SOAP format.
S – Take a history of their current status; question their goals for the coming year
O – Cover all the bases – Observations/ROMs/Palpations/Special Tests/ Vitals
A – What's going on now? What has changed?
Is the current treatment working as well as you'd hoped it would?
What are their current needs?
P – What's the plan for care going forward (next 6 months or year)
Include treatment frequency, type, referrals and self-care recommendations

So, there you have it – adequate notes for those patients who have 'no complaints'.