

Revisiting Documentation for the Pediatric Practice By Dr. Claudia Anrig

One of the more difficult tasks in a family chiropractic practice is to develop a protocol of documentation that allows you the balance of your time to perform the clinical assessment, give an adjustment, provide advice to parents regarding their child(ren), and record your recommendations. This article updates information I provided in an article several years ago (Nov. 18, 2004 *DC*), in the hope that I can shed additional light on ways to improve this overlooked area of practice. The intent of this article is not to set a standard that should be universal, but to provide an opportunity for family chiropractors to re-evaluate their documentation protocols and possibly invite new ideas to their procedures.

Forms

First, review your current case-history form. An adult case-history form does not cover the necessary information for the young child. Does the form include the necessary questions to understand the new child patient? For instance, does it include pregnancy and labor history, developmental milestones, and history of medication, trauma and childhood disorders? If your current form does not meet these criteria, you might want to consider reviewing the one I developed several years ago. To request a free sample, contact me [see Web site below].

You should also have an intake form that asks and/or reviews pertinent questions regarding the pediatric population. Questions concerning pregnancy, delivery/birth, childhood trauma, medical and present history may be important in developing a plan for the evaluation and care of the patient. If you would like a sample of the intake form that I currently use in my office, please go to www.drclaudiaanrig.com/main_free.html and click on "Handouts."

A consultation should always inquire thoroughly about the history of micro-/macrotrauma as a part of the assessment process. The past and current history of the child may assist in understanding the cause of any trauma to the pediatric spine and the vertebral subluxation complex. This may also help the doctor to understand whether this is an acute or chronic condition.

Examination forms should also give the doctor the opportunity to evaluate the patient. If a newborn has birth trauma, for example, does your exam form allow for neurological, orthopedic and chiropractic evaluation? If there are sections of the pediatric evaluation you choose not to perform, note why on the form. For example, if you are not going to perform an orthopedic or X-ray exam on the infant, you should record, "Omit due to age." If you do not want to perform a physical, you should note, "Last visit to pediatrician was [insert date], and all was WNL per mother."

Chiropractic Visits

During the chiropractic visit, the doctor, depending on their technique, should remain objective when evaluating the child. The age of the child and the doctor's technique will determine the evaluation protocol. The chiropractic evaluation might include one, if not several, of the following objective procedures: posture, gait, static and motion palpation, and instrumentation. It should be noted that in its earliest stages, the vertebral subluxation may not manifest as a clinically symptomatic disorder. Objective findings, not necessarily a symptomatic picture alone, should be the criteria for its identification.

During the visit, the doctor should inquire if there have been any new falls, tumbles or minor trauma since the child's last visit. Since many of the children we care for may not be able to give us an oral response to questions, record the parent's response. For example, "Per mother, son fell from steps of slides and hit back of neck" or "Per parent(s), since beginning care, improvement of [insert comment]." Additionally, record any instructions that you provided for the patient (ice, rest, recommended behavioral change, etc.).

Re-Examinations and Parent Participation

Not unlike with the adult patient, the specific nature of the child's condition will determine the frequency of re-examination. An auto injury usually requires re-evaluation every 30 days. I personally recommend that the parent fill out a form regarding the status of the child's progress at every re-evaluation. Participation from the parent regarding the progress of the child is very helpful. Furthermore, with respect to caring for children who have been involved in an auto injury, doctors should review Dr. Dan Murphy's chapter, "Children in Motor Vehicle Collisions," from the textbook *Pediatric Chiropractic*. This is a great reference tool for the field doctor.

For a child free from injury, depending on the age and clinical picture, re-evaluation between 45-60 days should be sufficient; however, each doctor should investigate the normal standard in their community or state. The pediatric re-evaluation may include additional tests that are not performed during a normal chiropractic visit.

For example, at each visit, the doctor may perform postural assessment with static and motion palpation. However at the time of the re-evaluation, performing cervical or lumbar range of motion may satisfy the criteria for additional assessment.

For those practices that use sEMG, this is also an excellent tool for a child re-evaluation visit. Creating an update form that parents can fill out prior to the re-evaluation may provide additional valuable information. For example, covering (but not excluding) the following areas may be useful in documenting your care program: recent falls and tumbles, positive or slow changes, activities that are difficult or painful for the child to perform, improved quality of life, or if the parents want their child to continue chiropractic care.

In conclusion, documentation will always be an evolving component in a chiropractic practice, and we should create the time to review and update this important procedure in our office.