

Motor, Reflex, Coordination and Sensory Screening Examination

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Motor Function

Lower Motor Neuron Testing

Handedness

- Right or Left Handed
- Ambidextrous
- Shoulder Height-levelness
 - Dominant side lower
- Grip Strength
 - Dominant side stronger by 10%
 - Female grip strength is 50% of males

Handedness

- Impairment Rating
 - Non-dominant often rated lower
- Side Posture Adjusting
 - Farfan's Torsion Test
 - Side of handedness up
- Pseudoambidexterity

Handedness

Pseudoambidexterity



Handedness

Pseudoambidexterity



True Ambidexterity

- Both ambidextrous and multilingual, 20th president James Garfield could write Greek with one hand while writing Latin with the other.

Bilateral Hand Shake

- Quick Assessment of Lower Cervical and Upper Thoracic Nerve Root Motor Function
- C₅-T₁



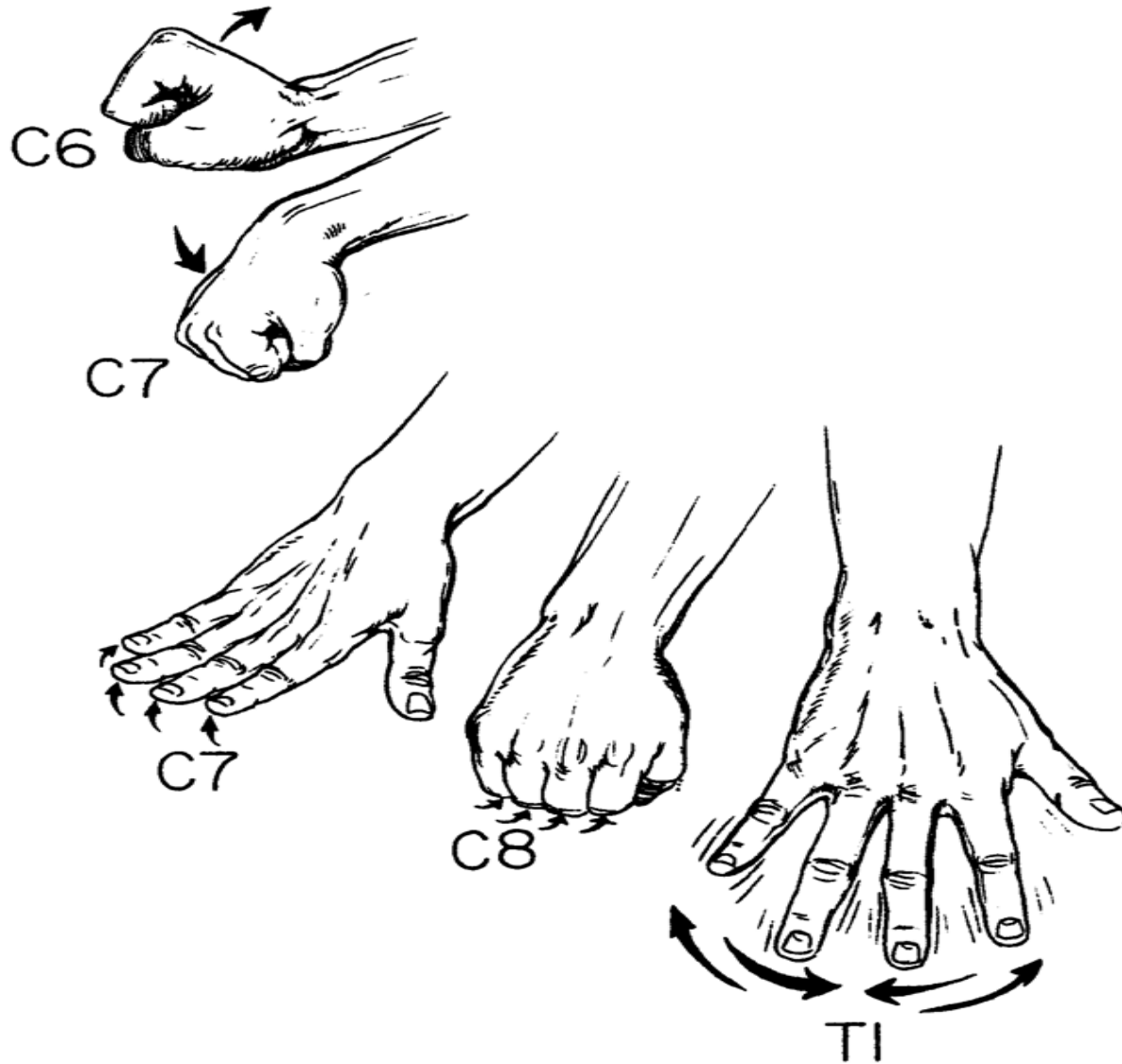


FIG. 1-29. Summary of muscle testing for the upper extremity.

Bilateral Hand Shake Test

- Flexion of the Shoulder-C₅
- Extension of The Elbow and Fingers-C₇
- Extending the Thumb-C₆
- Spreading the Fingers-T₁
- Bringing the Fingers Together-T₁
- Flexing the Fingers-C₈
- Wrist Stabilization-C₆/C₇
- Shaking (flex and extend the elbow)-C₅/C₇



Riding a Motorcycle

- Shoulder Flexion and Elevation to reach for the Handle Bars-C₅
- Spreading and Extending the Fingers Preparing to Grip the Bar-T₁/C₇
- Bringing the Fingers together and Flexing them to Grip Bar-T₁/C₈
- Using the Throttle-C₈/C₆
- Using the Clutch or Brake-C₇/C₈





CONSULTING

IF YOU'RE NOT A PART OF THE SOLUTION,
THERE'S GOOD MONEY TO BE MADE IN PROLONGING THE PROBLEM.

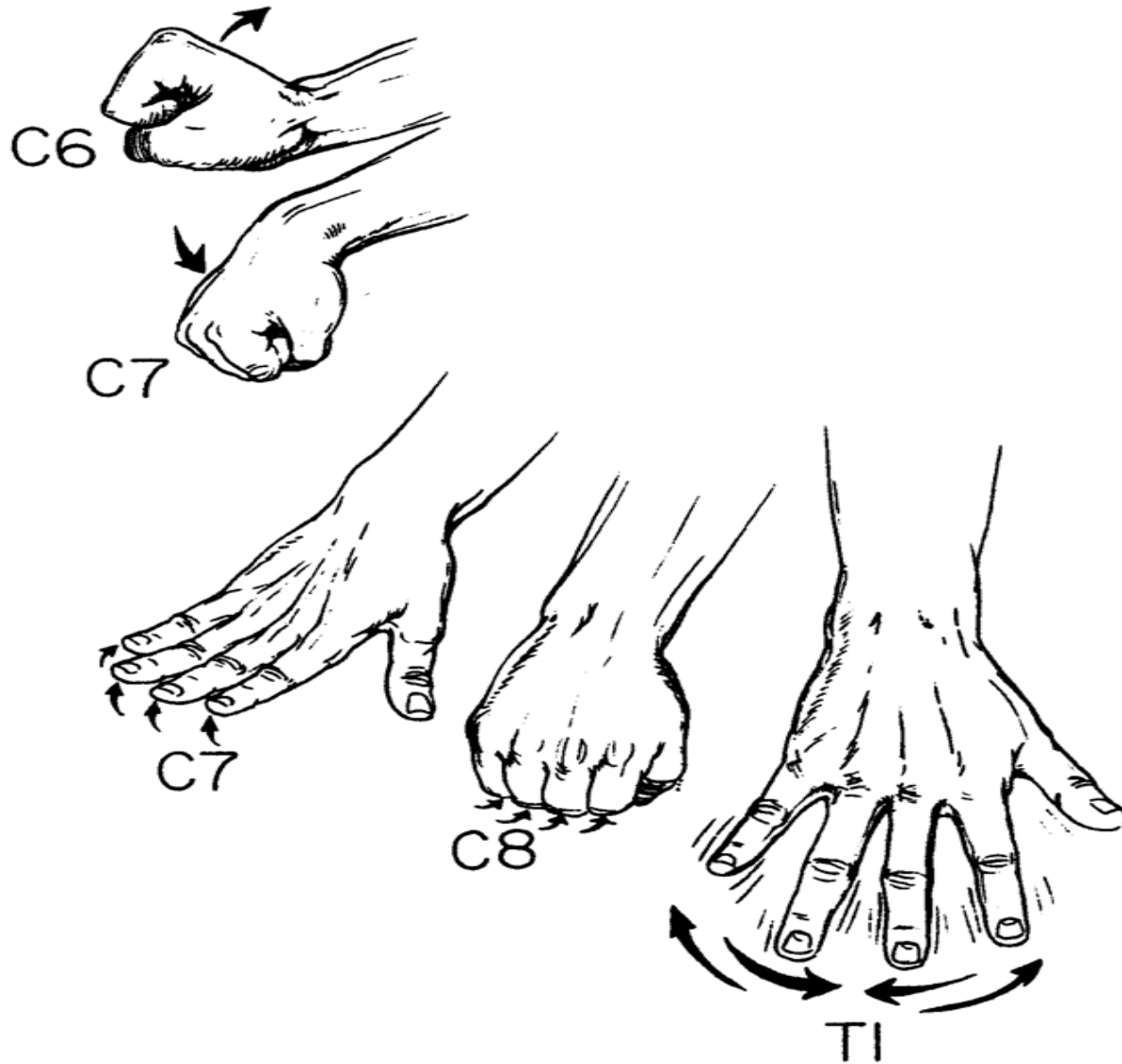


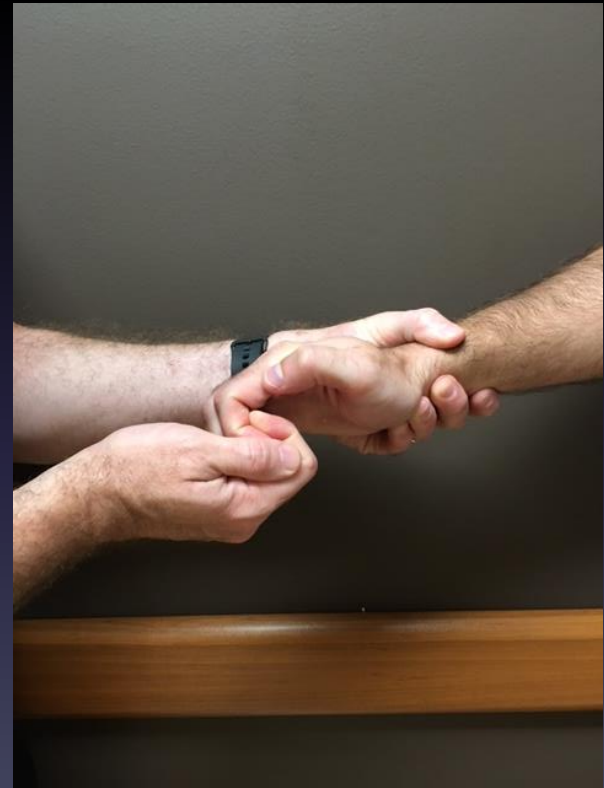
FIG. 1-29. Summary of muscle testing for the upper extremity.

Upper Extremity Motor

T₁ Finger abduction



C8 finger flexion



Upper Extremity Motor

C7 Finger Extension



C7 Wrist Flexion



Upper Extremity Motor

C6 Wrist Extension



C5 Arm Flexion



Upper Extremity Motor

- C7 Arm Extension



Muscle Testing Rules

- Test distal to the joint without crossing the next joint
- Hold for 5 seconds
- Do Not pump the muscle/joint
- Grade the contraction
- Differentiate between true weakness and reflexive weakness due to pain

Fingers Adductors/Abductors

- For adduction...squeeze method could bring finger flexion into play and skew results, use Rosenbaum card or similar
- Note the spring response for abductors

Finger Adductors



Medical Research Council Scale of Muscle Strength

"Record Keeping"

Grade	Response
0	No contraction
1	A flicker or trace contraction
2	Active movement with gravity eliminated
3	Active movement against gravity
4 ⁻	Active movement against gravity with slight resistance
4	Active movement against gravity with moderate resistance
4 ⁺	Active movement against gravity with strong resistance
5	Normal power

GRIP STRENGTH EVALUATION

Page of

NAME _____ DATE _____ CASE # _____

SEX _____ AGE _____ HANDEDNESS _____

HEIGHT _____ WEIGHT _____ OCCUPATION _____

LEFT HAND

Position 1 Position 2 Position 3 Position 4 Position 5

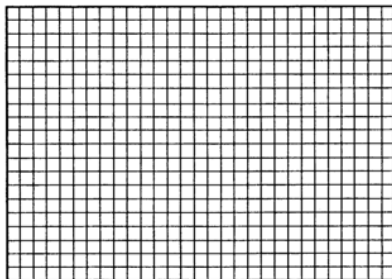
Average: _____

RIGHT HAND

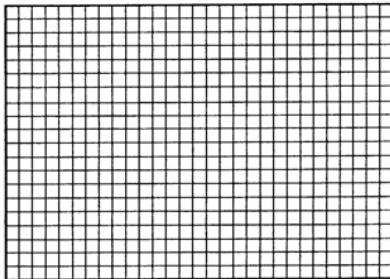
Position 1 Position 2 Position 3 Position 4 Position 5

Average: _____

LEFT HAND



RIGHT HAND



DOCTOR'S NOTES

Grip Strength

GRIP STRENGTH EVALUATION

Page _____ of _____

NAME K. J. Miller DATE 9-27-02 CASE # _____
 SEX male AGE 39 HANDEDNESS (R)
 HEIGHT 5-11 WEIGHT 208 OCCUPATION Chiropractor

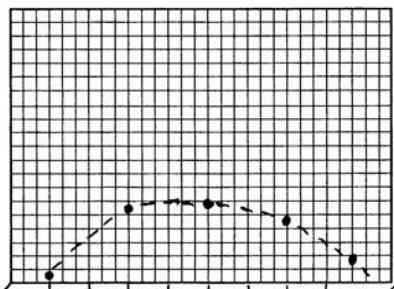
LEFT HAND

	Position 1	Position 2	Position 3	Position 4	Position 5
	<u>29 kg</u>	<u>52 kg</u>	<u>56 kg</u>	<u>52</u>	<u>34</u>
	<u>28</u>	<u>54</u>	<u>56</u>	<u>48</u>	<u>34</u>
	<u>30</u>	<u>54</u>	<u>58</u>	<u>48</u>	<u>32</u>
Average:	<u>29 kg</u>	<u>53 kg</u>	<u>57 kg</u>	<u>49 kg</u>	<u>33 kg</u>

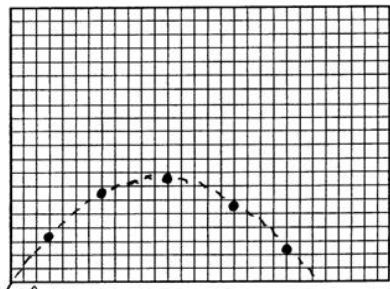
RIGHT HAND

	Position 1	Position 2	Position 3	Position 4	Position 5
	<u>42 kg</u>	<u>60 kg</u>	<u>64</u>	<u>52</u>	<u>36</u>
	<u>44</u>	<u>56</u>	<u>60</u>	<u>52</u>	<u>34</u>
	<u>40</u>	<u>60</u>	<u>62</u>	<u>52</u>	<u>36</u>
Average:	<u>42 kg</u>	<u>59 kg</u>	<u>62 kg</u>	<u>52 kg</u>	<u>35 kg</u>

LEFT HAND



RIGHT HAND



DOCTOR'S NOTES _____

Grip Strength

Quick Test

- Test for Motor Function Of Nerve Roots L2-S2 and Lower Extremity Range of Motion (hip, knee and ankle)
- Alternate Version



Quick Test

Motor innervation for lower extremity movements performed during
deep knee bends

Movement	Nerve Root Level
-----------------	-------------------------

HIP

flexion	L2-L3
---------	-------

extension	L4-L5
-----------	-------

KNEE

extension	L3-L4
-----------	-------

flexion	L5-S1
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ANKLE

dorsiflexion	L4-L5
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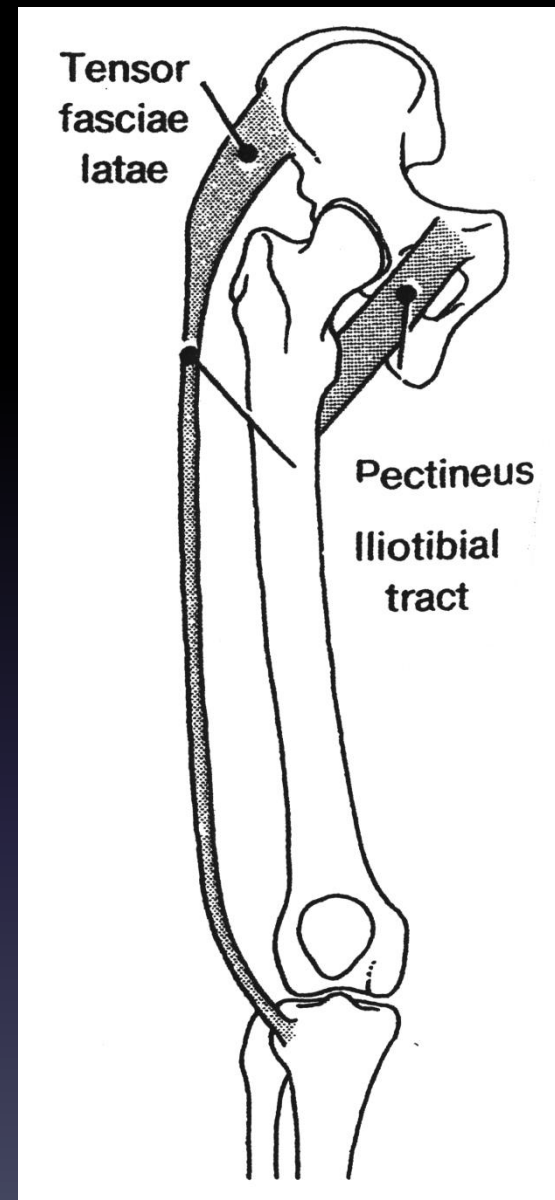
planar flexion	S1-S2
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Hoppenfeld

- Gluteus Maximus (S₁)
 - S₁ strength is usually WNL if the patient can move from sitting to standing without using the hands to push up

The IT Band

- Snapping
- Crepitus
 - Repetitive
 - Non-repetitive
- Trochanteric Bursitis
- Ober's and Noble's Tests



Heel Walking L4-L5

- Marching in place on the heels
- Stabilize
- Space considerations

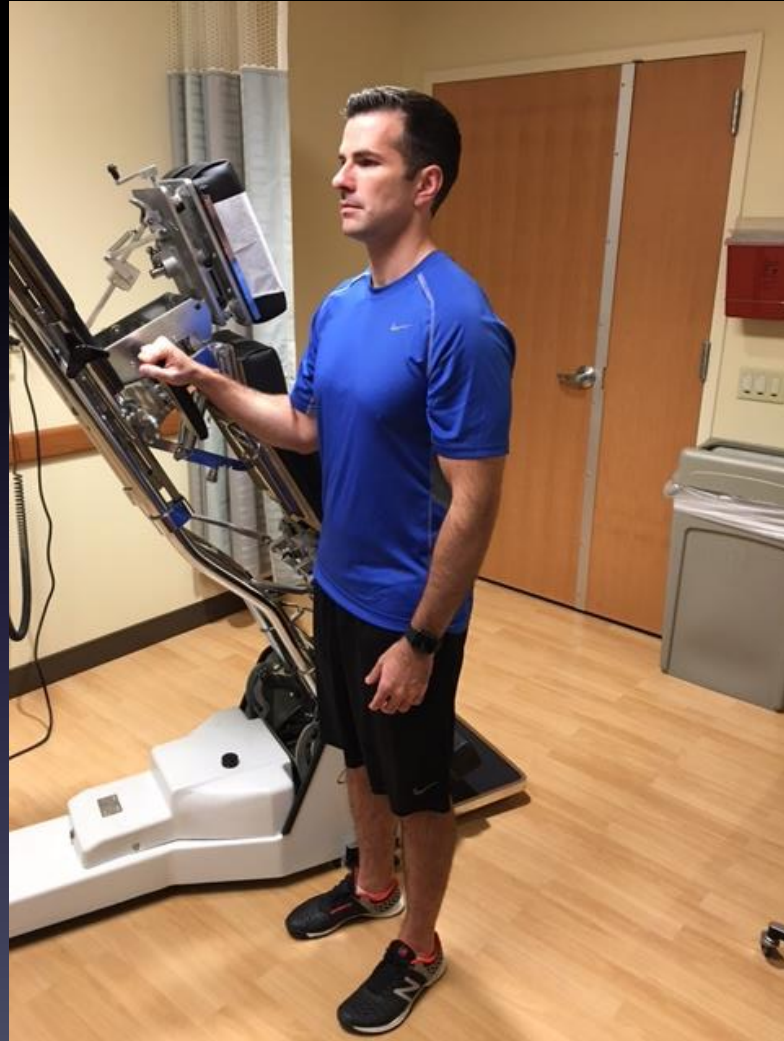


Toe Raises S₁-S₂

- 25 Bilateral Repetitions
 - McNab
 - 15 unilateral
 - Hoppenfeld
 - Hop on foot
 - Manual?
- Stabilize
- Space Considerations



Starting Position



Lower Extremity Motor

Toe Raises



Heel Standing/Marching



Muscle Testing at the Feet

- Foot Dorsiflexion L₄
- Great Toe Extension L₅
- Toe Flexion S₁-S₂



Motor Function

Upper Motor Neuron Testing

Hautant's - Drift Test

- Vertebral Artery Test
- Doctor Should Position Patient's Head
- Eyes Must be Closed
- Held 15-30 Seconds Each Side
- **Drift**
 - Objective
 - Validity by Common Use





Drift

- Basic Life Support (BLS)
 - American Heart Association
 - Cincinnati pre-hospital stroke
- Scale (one positive)
 - Facial droop
 - Arm drift
 - Abnormal speech
- Acceptance/Reliability

Drift

- F.A.S.T.
 - Face
 - Arms
 - Speech
 - Time

Drift

- Names
 - Drift
 - Pronator Drift
 - Spontaneous Drift
 - Barre's Test (some confusion here because there is a Barre's test for the cervical spine)
 - Jean Alexandre Barre' first described the sign

Drift

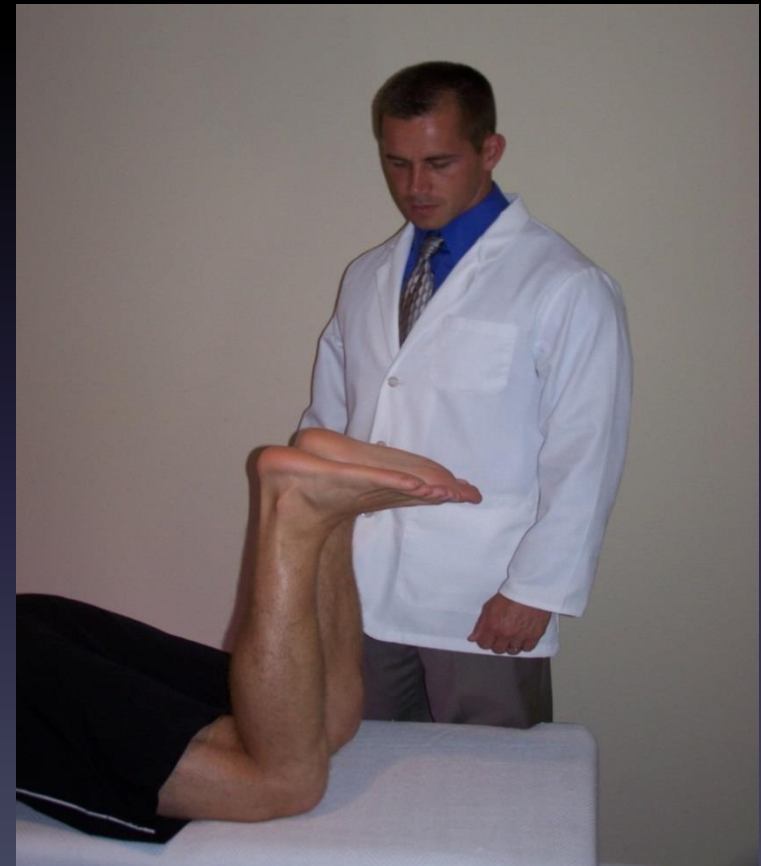
- Positive Indications:
 - One hand rolling from supination to pronation is a positive
 - Typical sign is the hand rolling from supination to pronation with the arm dropping toward the floor
 - The arm drifts laterally (outward) in cerebellar lesions
 - These lesions are unilateral
 - The arm drifts upward in Parietal lesion
 - These lesions are contralateral

Drift

- Positive Indications:
 - Movements are slow and may take a few seconds to initiate
 - Tapping the hand or arm may help initiate movement
 - Both arms drifting is not significant

Lower Extremity Drift Starting and Normal

- This is a side note
- Confirmatory Test to Upper Extremity Drift (UMN)



Miller 2002

Lower Extremity Drift Abnormal

- This is a side note
- Are the eyes closed?
- Does it matter?



Miller 2002

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Arm Rolling & Finger Rolling

- Test for UMN
 - Forward and backward



Arm Rolling & Finger Rolling

- Pathological Findings
 - Arm Rolling
 - The pathological arm remains stationary or wobbles a little while the non-pathological arm rotates around it like a satellite.
 - Finger Rolling
 - The pathological finger remains stationary or wobbles a little while the non-pathological finger rotates around it like a satellite.
 - Finger Rolling is **more sensitive** than Arm Rolling

Investigative Progression of Physical Examination

Progression → Structure/Function Pathology ↓	History	Observation	Baseline Testing	Evolution of Testing	Further Evolution of Testing
Lower Motor Neuron Upper Extremity Motor Strength Grip Strength	<ul style="list-style-type: none"> • Patient reports loss of strength • Patient reports dropping items 	<ul style="list-style-type: none"> • Muscle atrophy of the upper extremity/hand 	<ul style="list-style-type: none"> • Hand shake 	<ul style="list-style-type: none"> • Strength testing individual muscles 	<ul style="list-style-type: none"> • Dynamometer testing
Upper Motor Neuron Strength	<ul style="list-style-type: none"> • Patient reports weakness 	<ul style="list-style-type: none"> • Possible Spasticity 	<ul style="list-style-type: none"> • Drift • Arm Rolling • Finger Rolling 	<ul style="list-style-type: none"> • Referral • EMG 	

Investigative Progression of Physical Examination

Progression → Structure/Function Pathology ↓	History	Observation	Baseline Testing	Evolution of Testing	Further Evolution of Testing
Lower Motor Neuron Lower Extremity Motor Strength	<ul style="list-style-type: none"> • Patient reports loss of strength • Patient reports difficulty raising from a chair • Patient reports difficulty with climbing/descending stairs 	<ul style="list-style-type: none"> • Muscle atrophy of quad, hamstring, calf musculature 	<ul style="list-style-type: none"> • Heel and toe walking • Heel standing/toe raises • Quick test • Going from sitting to standing 	<ul style="list-style-type: none"> • Strength testing individual muscles • Sit to Stand Test 	<ul style="list-style-type: none"> • Dynamometer testing
Upper Motor Neuron Strength	<ul style="list-style-type: none"> • Patient reports weakness 	<ul style="list-style-type: none"> • Possible atrophy • Spasticity 	<ul style="list-style-type: none"> • Drift 	<ul style="list-style-type: none"> • Referral • EMG 	

Reflex Function

DTR and Pathological Testing

Hammer Selection



Hammer Selection



Antique Hammers

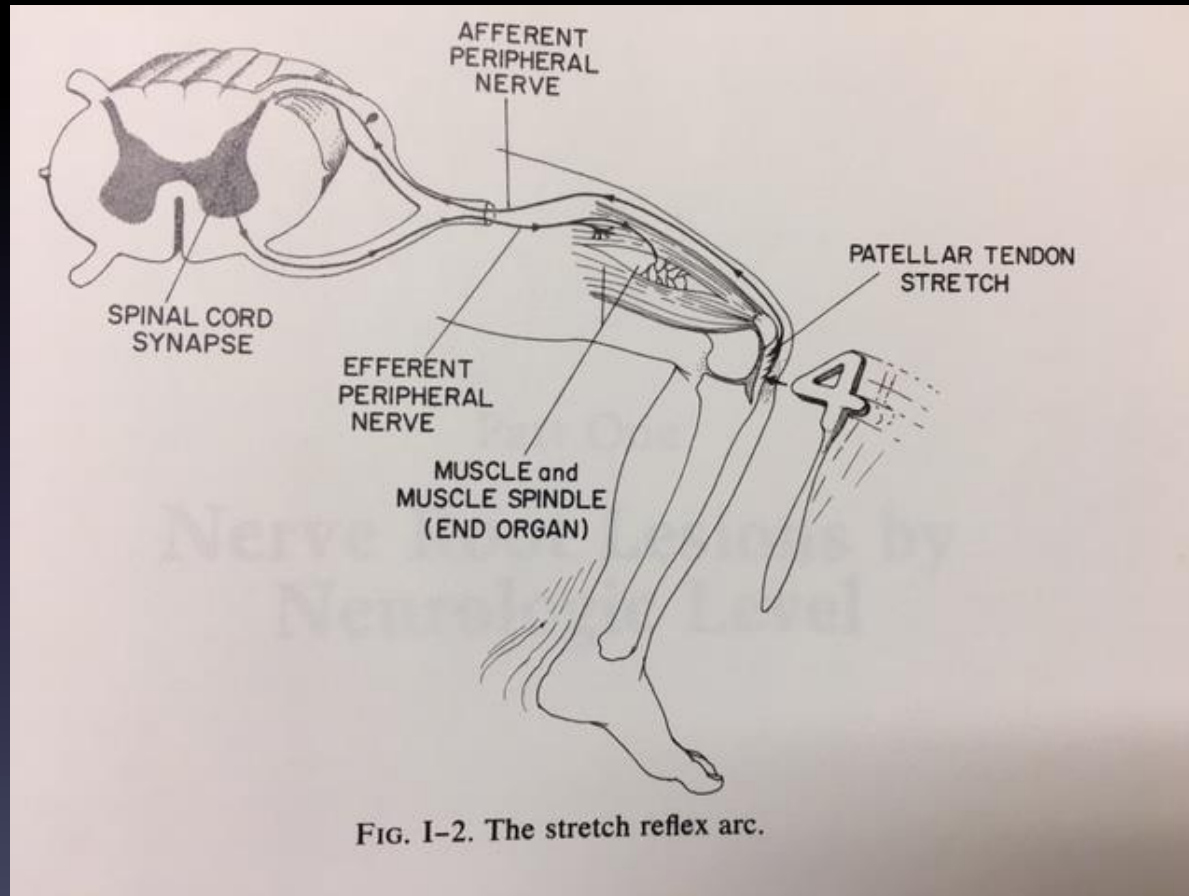
- Dejerine Hammer
- Berliner Hammer
- Queen's Square Hammer
- Taylor Hammer (Looped Handle)
- Queen's Square Hammer
- Traube Hammer
- Taylor Hammer (Solid Handle)



Reflex Performance

- You get what you pay for here
 - Weight and length of the handle
- Practice using both hands-dimes on a desk
- Multiple Taps
- Symmetry vs the Wexler Scale
- Striking the tendon vs the muscle belly
- Jendrassik Maneuver

Deep Tendon Reflex Arc



Biceps Reflex

- C₅-C₆
- Symmetry
- Multiple Taps



Brachioradialis Reflex

- C₅-C₆
- Symmetry
- Multiple Taps



Brachioradialis Reflex

Identify the muscle belly

Identify The Muscle Belly



Brachioradialis Reflex

- STRIKING THE BELLY



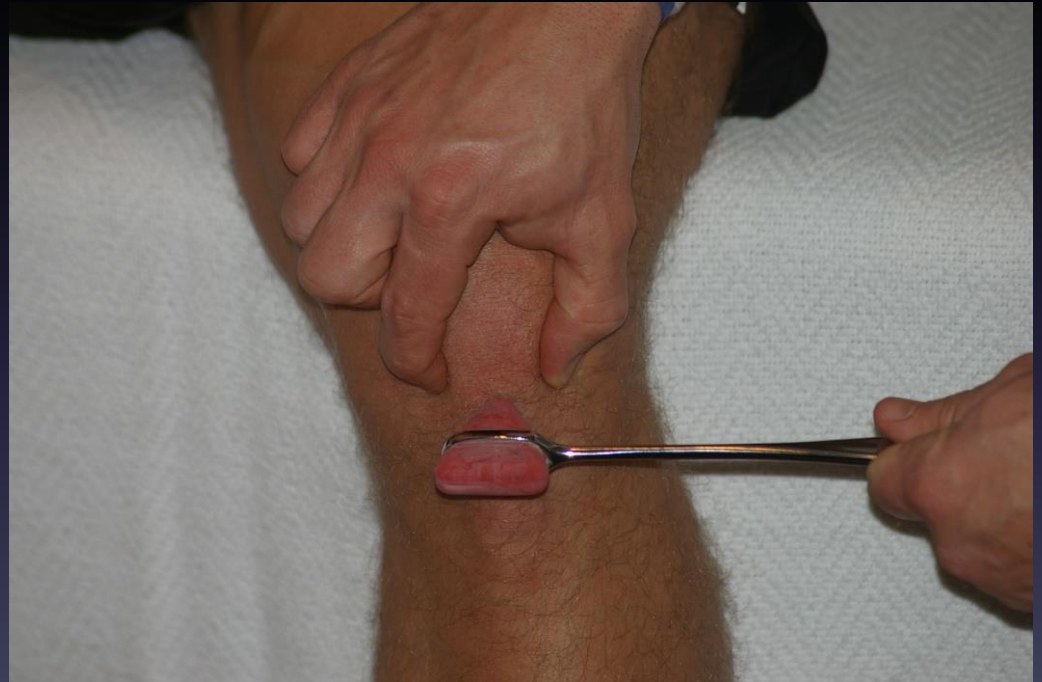
Triceps Reflex

- C7
- Symmetry
- Multiple Taps



Patellar Reflex

- L₂, L₃ & L₄
- Symmetry
- Multiple Taps



Achilles Reflex

- S₁-S₂
- Symmetry
- Multiple Taps



Wexler's Scale for Grading Deep Tendon Reflexes

"Record Keeping"

Grade	Response
Grade 5+	Sustained clonus
Grade 4+	Clonus
Grade 3+	Hyperreflexia
Grade 2+	Normal
Grade 1+	Hyporeflexia
Grade 0	No reflex

Deep Tendon Reflex (DTR) Summary

- Biceps **Musculocutaneous** C₅-C₆
- Brachioradialis **Radial** C₅-C₆
- Radial **Radial** C₅-C₆
- Triceps **Radial** C₇
- Patellar **Femoral** L₂-L₄
- Achilles **Tibial** S₁-S₂

Deep Tendon Reflex (DTR) Summary

- Extensor Hallucis Longus **Deep Peroneal** L4, L5, L6
- Pec Major (Pectoral) **Med/Lat Pectoral**
 - C5-C6 Clavicular Head, C7-C8, T1 Sternocostal head
- Medial Hamstring **Sciatic** L5, L6
- Masseter (Jaw Jerk) **Trigeminal (CN V)**

Extensor Hallucis Longus



Hoffman's Reflex

- Test for UMN Lesions
- Upper Extremity Equivalent of Babinski's Sign
- Must Be Firm
 - Fake finger nails
 - Partially amputated fingers

Hoffman's Reflex



Babinski's Reflex

- Test for UMN Lesions
- Most Common UMN Test
- Must Be Firm
- Present or Absent
 - Up Going or Down Going

Babinski's Reflex



Investigative Progression of Physical Examination

Progression → Structure/Function Pathology ↓	History	Observation	Baseline Testing	Evolution of Testing	Further Evolution of Testing
Deep Tendon Reflexes	NA	NA	<ul style="list-style-type: none"> Biceps C₅-C₆ Brachioradialis C₅- C₆ Triceps C₇ Patellar L₄ Achilles S₁ 	<ul style="list-style-type: none"> Re-enforcement Additional Reflexes Other types for tests for the same root level 	<ul style="list-style-type: none"> Advanced imaging Referral
Pathological Reflexes	NA	NA	<ul style="list-style-type: none"> Hoffman's Babinski's 	<ul style="list-style-type: none"> Additional pathological reflexes, upper and lower extremities 	<ul style="list-style-type: none"> Advanced imaging Referral

Coordination Function

Neurological Testing

Important Point

- It isn't just the fact that the patient finds/touches his nose...
 - It must be done repeatedly and the movements must be smooth and on target

Finger to Nose Test

- Cerebellar Test
 - Coordination
- Eyes Closed
- This isn't Just Touching the Nose
 - Fast, Smooth and on Target



Finger to Nose Test



Coordination

Heel to Shin test

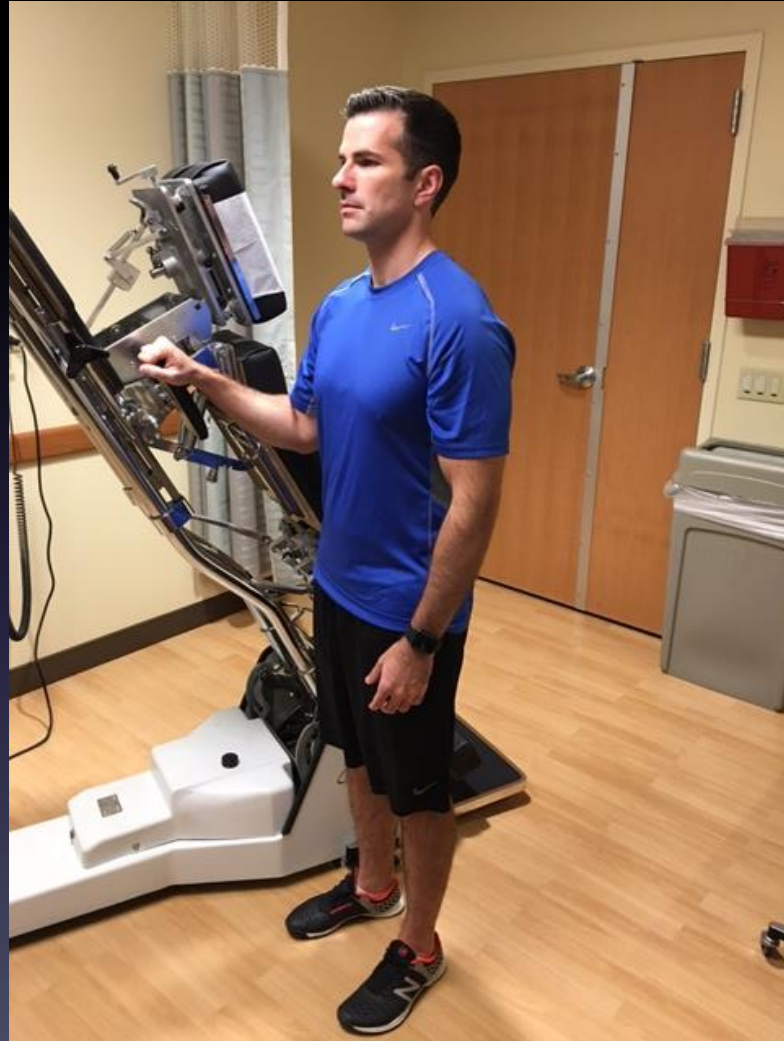


Tandem Stance

- Cerebellar Test
 - Coordination
- Eyes Closed
- Tandem stance is Harder than Tandem Walking or Romberg's tests due to the testing position having a more narrow base
 - Magee, Dutton
- Also referred to as Sharpened Romberg's Test or Tandem Romberg Test
- You can also grade this = **partial tandem**



Starting Position



Tandem Stance



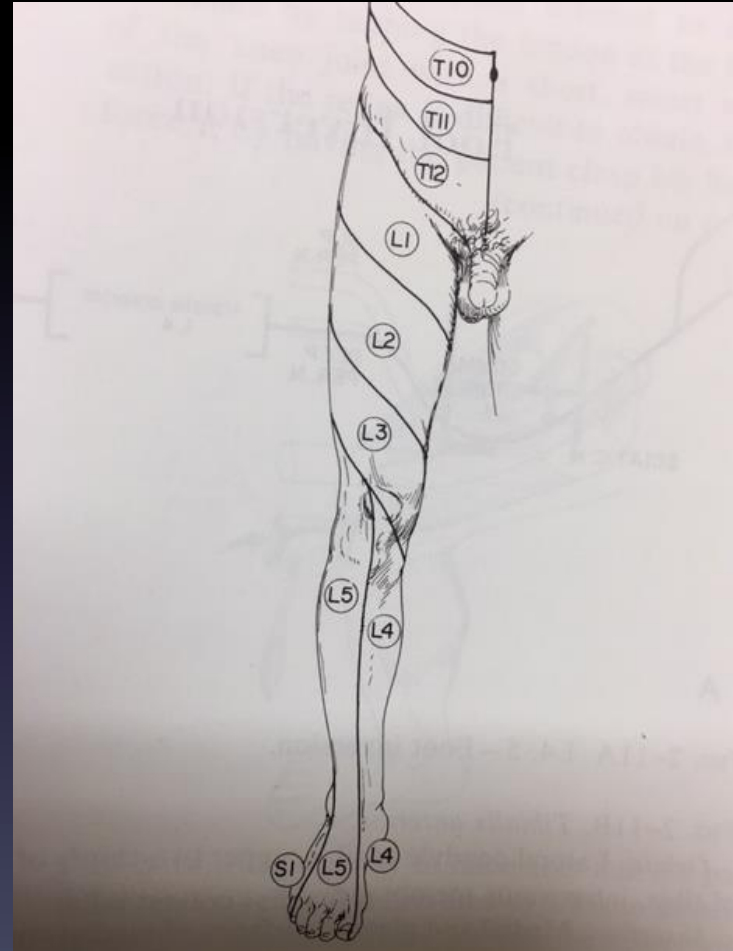
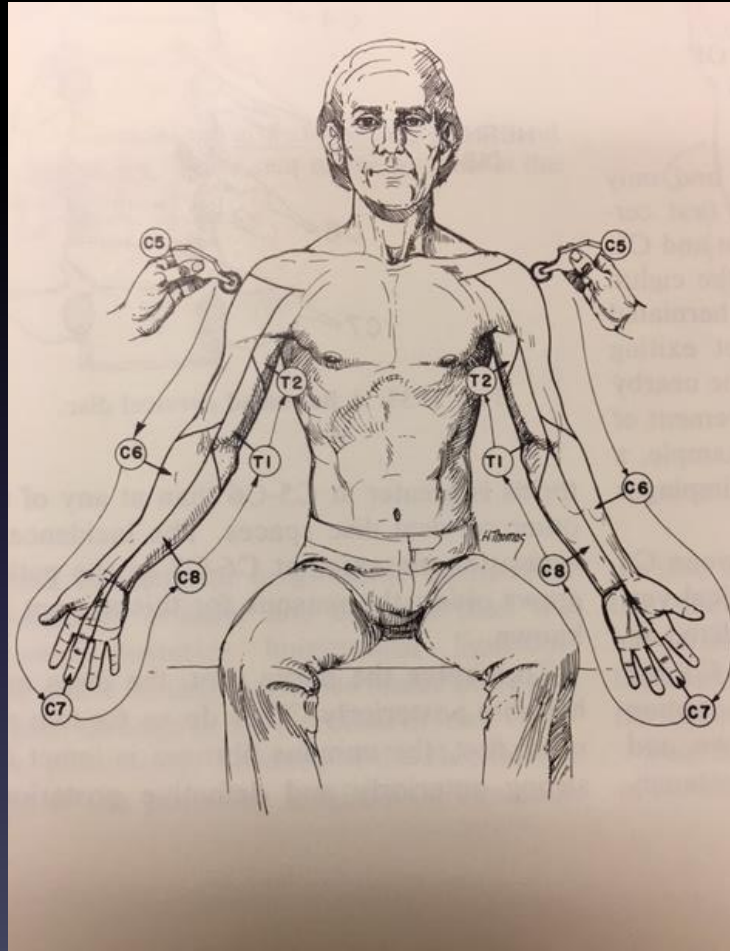
Investigative Progression of Physical Examination

Progression → Structure/Function Pathology ↓	History	Observation	Baseline Testing	Evolution of Testing	Further Evolution of Testing
Upper Extremity Coordination	<ul style="list-style-type: none"> • Patient reports a decrease in hand coordination 	<ul style="list-style-type: none"> • Poor handwriting • Lack of coordination in arm movements 	<ul style="list-style-type: none"> • Finger to nose • Rapid alternating movements 	<ul style="list-style-type: none"> • Finger to finger test • Past pointing test • Drift • Arm rolling • Finger rolling 	<ul style="list-style-type: none"> • Advanced imaging • Referral
Lower Extremity	<ul style="list-style-type: none"> • Patient reports a loss of balance 	<ul style="list-style-type: none"> • Ataxic gait • Walking with a wide stance 	<ul style="list-style-type: none"> • Tandem Stance 	<ul style="list-style-type: none"> • Romberg's Test • Tandem Walk • Heel to Shin test 	<ul style="list-style-type: none"> • Advanced imaging • Referral

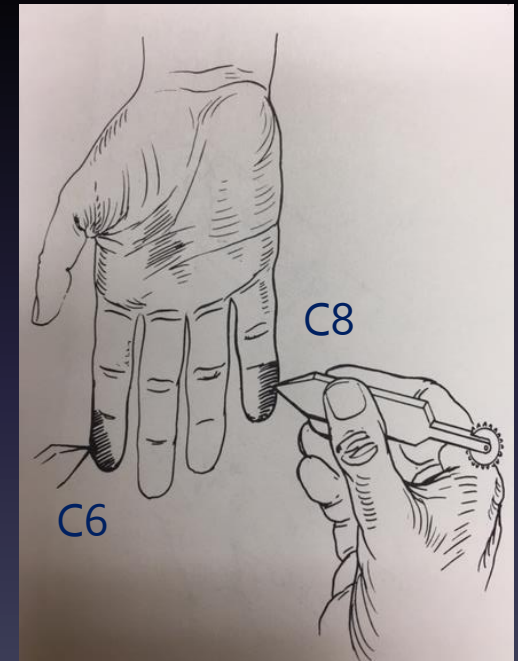
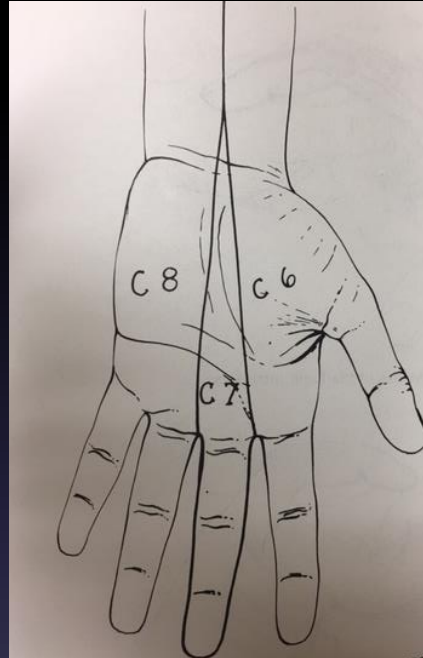
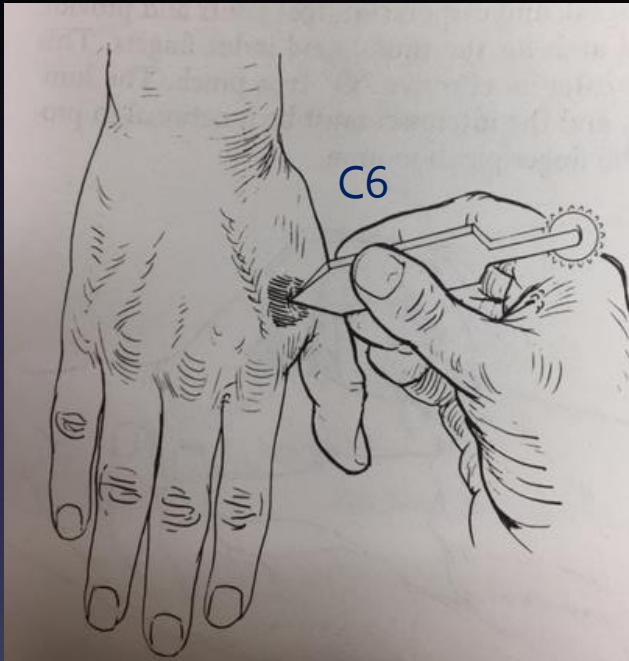
Sensory Function

Neurological Testing

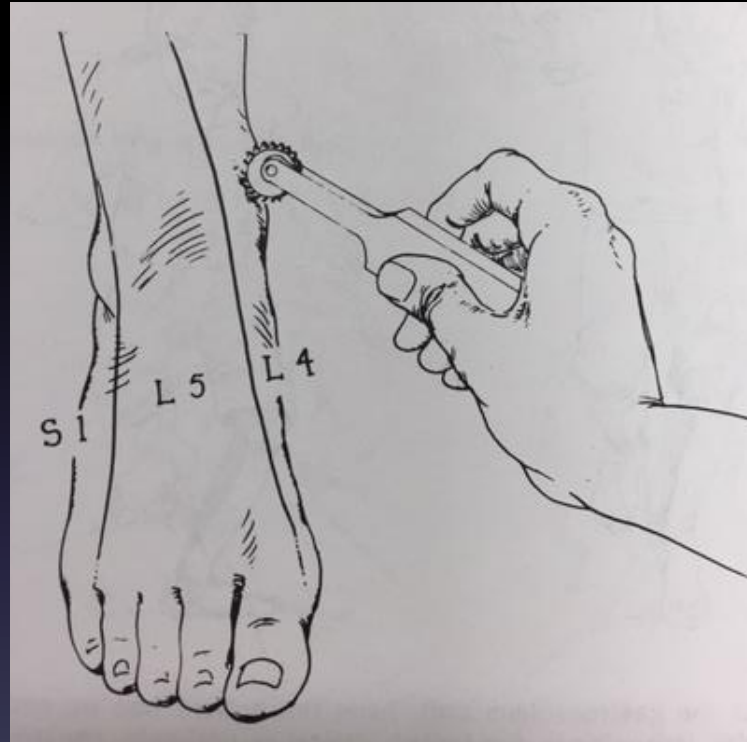
Dermatomes



Dermatomes



Dermatomes



Sensory Testing Tools



Sensory

- Major Dermatomes and Peripheral Nerves of the Hand and Foot
- Why test these locations?
- Sensory tests are my least favorite neurological tests- subjective
 - Dermatome and Peripheral nerve innervation of the skin is highly variable

Upper Extremity Sensory



Foot Sensation



Investigative Progression of Physical Examination

Progression → Structure/Function Pathology ↓	History	Observation	Baseline Testing	Evolution of Testing	Further Evolution of Testing
Sensation	<ul style="list-style-type: none"> • Patient reports numbness "dead" areas • Patient report an inability to feel his feet 	<ul style="list-style-type: none"> • NA 	<ul style="list-style-type: none"> • Sensation scan (run hands down arms and legs) 	<ul style="list-style-type: none"> • Tissue • Tooth picks 	<ul style="list-style-type: none"> • Sharp and dull • Light touch • Vibration • Proprioception • Two point discrimination • Hot/Cold • Graphesthesia • Stereognosis • Advanced imaging • Referral

OTHER SENSORY FUNCTIONS AND TESTS

Know these Tracts

- Spinothalamic Tract Pain & Temperature
 - Posterior Column Proprioception & Stereognosis &
Light Touch
 - Spinocerebellar Tract* Proprioception
 - Corticospinal Tract Motor Function
- The only tract that does not cross over

Sharp-Dull



- Test along the course of dermatomes/peripheral nerves
- Wattenberg Pin Wheel
- Problems with safety
 - Sanitation
 - Breaking the skin
- Pointed vs cutting ends

Sharp-Dull

- Problems with safety
 - Sanitation
 - Breaking the skin
- Pointed vs cutting ends
- Tooth picks

Light Touch

- Usually spared in unilateral cord lesions
- If pain and proprioception are intact then light touch will not likely be effected
- So only test light touch if deficiencies of the pain and proprioception are found

Light Touch



Light Touch

- Tissues for Light Touch
 - Readily available
 - Cheap
 - Clean-disposable

Sensory Testing Tips

- Facial Sensation CN 5
 - A lesion will likely effect all three branches of the sensory nerve.
 - Over 90% of lesions effect the maxillary branch
- Tuning form for hot cold comparison
 - Near heating/cooling vent if possible

Vibration

- Use a 128 Hz tuning fork with weighted ends
- Testing locations
 - Great toe
 - Metatarsal heads
 - Malleoli
 - Tibia
 - Anterior superior iliac spine
 - Scrum
- Testing locations continued
 - Spinous processes
 - Sternum
 - Clavicle
 - Radius/ulna styloid processes
 - Finger joints

Vibration

- Sensitive test as the nervous system must perceive, transmit and interpret rapidly changing stimulus
- Lack of the sensation indicates peripheral nerve and/or posterior columns

Proprioception

- Position sense: knowledge of where body parts are in space
- Unilateral dorsal column that crosses over in the brain stem
- Test distally and move proximal if necessary

Proprioception

- Drift, arm rolling, finger rolling, Romberg's test, tandem stance are depend upon proprioception but also vestibular and cerebellar function
- So...the individual testing isn't always immediately necessary in chiropractic clinical practice. When it is it will usually be for patient's with head injury, cerebral/cerebellar ischemia or the elderly in general

Two Point Discrimination



Two Point Discrimination

- The purpose is to assess if the patient can differentiate between being touched by one or two different points of contact
- Multiple tools are available
- The test can be performed static and/or moving. Moving is considered more accurate

Two Point Discrimination

- Any number of sensory pathologies central or peripheral can cause positive findings. Peripheral pathologies more common
- The most common concern is diabetes
- Posterior columns, medial lemniscus

Two Point Discrimination

- Tip of the tongue 1 mm
- Lips 2-3 mm
- Finger tips 2-4 mm
- Dorsum of the fingers 4-6mm
- Palm 8-12 mm
- Back of hand 20-30 mm
- Dorsum of foot 30-40 mm

Monofilament

- Used frequently with diabetic patients
- Compare to two point discrimination



Hot and Cold

- Spinothalamic tract with pain
- If pain is intact hot and cold usually will be as well
- Tubes of hot and cold water
 - Cold of warm metal instruments

Stereognosis

- The ability to identify objects by touch and/or differentiate objects by touch or identify textures
- Palpation/Braille
- Parietal Lobe Function
- Depends on intact lower neurological functions
- Can only be tested at the hand

Stereognosis



Stereognosis



Graphesthesia

- The ability to recognize letters or numbers written on the skin with a pencil, dull pin, or similar object
- Parietal Lobe Function
- Depends on intact lower neurological functions
- Right side up or upside down
- Must use dissimilar numbers and letters

Graphesthesia

- Remember – You are not really drawing the letters/numbers



Question

- After I published the first edition of *Practical Assessment* I was frequently asked, “What do I do if the patient cannot move or every tests is painful for the patient?”

Micro-systems



Concentrated Neurological Examination

Neurological “Microsystem”

- Upper motor
- Lower Motor
- Coordination
- Pathological Reflexes
- Stereognosis
- Graphesthesia
- Sensation
 - Sharp/dull
 - Light touch
 - Hot/cold
- Vibration
- Proprioception

SPECIALTY EXAM: NEUROLOGY

Refer to data section (table below) in order to quantify. After reviewing the medical record documentation, identify the level of examination. Circle the level of examination with the appropriate grid in Section 5 (Page 3).

Performed and Documented	Level of Exam
One to five bullets	Problem Focused
Six to eleven bullets	Expanded Problem Focused
Twelve or more bullets	Detailed
At least one bullet in the box with the unshaded border AND every bullet in each box with the shaded borders.	Comprehensive

(Circle the bullets that are documented.)

NOTE: For the descriptions of the elements of examination containing the words "and", "and/or", only one (1) of those elements must be documented.

System/Body Area	Elements of Examination
Cardiovascular	<ul style="list-style-type: none"> Examination of carotid arteries (e.g., pulse amplitude, bruits) Auscultation of heart with notation of abnormal sounds and murmurs Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)

Constitutional	<ul style="list-style-type: none"> Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Eyes	<ul style="list-style-type: none"> Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)
Musculoskeletal (Includes Extremities)	<ul style="list-style-type: none"> Examination of gait and station <p>Assessment of motor function including:</p> <ul style="list-style-type: none"> Muscle strength in upper and lower extremities Muscle tone in upper and lower extremities (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (e.g., fasciculation, tardive dyskinesia)

HIC#	DATE OF SERVICE
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System/Body Area	Elements of Examination
Neurological	<p>Evaluation of higher integrative functions including:</p> <ul style="list-style-type: none"> Orientation to time, place and person Recent and remote memory Attention span and concentration Language (e.g., naming objects, repeating phrases, spontaneous speech) Fund of knowledge (e.g., awareness of current events, past history, vocabulary) <p>Test the following cranial nerves:</p> <ul style="list-style-type: none"> 2nd cranial nerve (e.g., visual acuity, visual fields, fundi) 3rd, 4th, and 6th cranial nerves (e.g., pupils, eye movements) 5th cranial nerve (e.g., facial sensation, corneal reflexes) 7th cranial nerve (e.g., facial symmetry, strength) 8th cranial nerve (e.g., hearing with tuning fork, whispered voice and/or finger rub) 9th cranial nerve (e.g., spontaneous or reflex palate movement) 11th cranial nerve (e.g., shoulder shrug strength) 12th cranial nerve (e.g., tongue protrusion) Examination of sensation (e.g., by touch pin, vibration, proprioception) Examination of deep tendon reflexes in upper and lower extremities with notation of pathological reflexes (e.g., Babinski) Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children)

Note: The Head/Face; Ears, Nose, Mouth and Throat; Neck; Respiratory; Chest (Breasts); GI (Abdomen); GU; Lymphatic; Sk and Psychiatric systems/body areas are not integral parts of this Neurological exam.

(Enter the number of circled bullets in the boxes below. Then circle the appropriate level of care.)

EXAM	One to Five Bullets	Six to Eleven Bullets	Twelve or more Bullets	Answer the following two questions. If both answers are "yes," the appropriate level of exam is comprehensive. Was at least one bullet documented in the unshaded box? <input type="checkbox"/> Yes <input type="checkbox"/> No Was each bullet in each shaded box documented? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive