The Physical Examination

A major component of clinical record keeping is recording the physical examination, which is an extension of the clinical history. It narrows down the differential diagnosis and helps set up the plan of management. A physical exam involves procedures that, when looked at in the scope of the entire chart, are appropriate to the chief complaint and history information, and are supportive of the working diagnosis and treatment plan. Hence, the process of intake progresses logically toward the recommendation for treatment, and the patient chart should demonstrate that unbroken progression.

The vast scope of diagnostic procedures and tests available to doctors would be impossible to cover in this article, however, it is assumed that the reader has substantial fundamental knowledge of foundational examination procedures required in the primary contact environment of chiropractic practice in Alberta. This document serves to reinforce the importance of performing and appropriately recording this aspect of the patient visit. The success of your Practice Review will depend on it, and should future legal concerns arise, your chart notes will be prepared for third party scrutiny.

CCOA Clinical Advisors have observed in member Practice Review self-submissions that there are several ways practitioners record data during the physical exam. The most common is a checkmark placed beside a named test in a list of tests. Although this may at times meet a minimal standard for some tests, the reader of such a chart is likely to wonder how a checkmark in a checkbox (e.g., ☑) next to the Straight Leg Raise test provides useful information. In this era of increasing emphasis on clinical documentation, a checkbox may not qualify as sufficient; many examination tests require the inclusion of some objective information to be useful and to meet review standards. In the unfortunate event of a complaint or litigation, having data recorded that states, for example, “positive SLR at 40 degrees with pain to posterior leg and calf” would serve as more useful information. This additional information is also far more informative as a reference for progress re-evaluation and for potential legal issues.

Much of the diagnosis comes from the clinical history. The physical exam is the process in which we:

- confirm or rule out clinical perceptions thus far
- correlate gathered data to date, and
- make decisions on the requirement for imaging, third party testing, or referral to specialty consultants

This process leads the practitioner toward the determination of the differential diagnosis. By the time a clinical history is complete, the practitioner has already started to gather extremely important information that is relevant to the physical exam, via observation of the patient.

The practitioner has already had the opportunity to observe the patient’s general physical and emotional state. The practitioner has had the opportunity to view the patient’s movement in the exam room, the presence or absence of antalgic postures, and countless other details. Doctors of chiropractic observe these in order to assess the character of the presenting complaint, aid in taking history, and provide direction for physical exam procedures. Of note here is that the physical exam does not begin after the history; the physical exam begins the moment the practitioner lays eyes on the patient. What tests are chosen, which instruments are employed, and what studies are ordered are informed by the information gathered in the history, and should extend the logical pursuit of the presenting complaint.

The key message is: document the information. The physical exam is an art form of data-gathering and efficiency. Choosing tests that are useful, diagnostic and confirmatory is essential to an accurate diagnosis. Documenting this process is necessary to create a complete chart, and this is the expectation in the Practice Review standard.