148.107 RECORD KEEPING.

All items in this section should be contained in the patient record, including, but not limited to, clauses (1), (2), (3), (5), (7), and (9).

(1) A description of past conditions and trauma, past treatment received, current treatment being received from other health care providers, and a description of the patient's current condition including onset and description of trauma if trauma occurred.

(2) Examinations performed to determine a preliminary or final diagnosis based on indicated diagnostic tests, with a record of findings of each test performed.

(3) A diagnosis supported by documented subjective and objective findings, or clearly qualified as an opinion.

(4) A treatment plan that describes the procedures and treatment used for the conditions identified, including approximate frequency of care.

(5) Daily notes documenting current subjective complaints as described by the patient, any change in objective findings if noted during that visit, a listing of all procedures provided during that visit, and all information that is exchanged and will affect that patient's treatment.

(6) A description by the chiropractor or written by the patient each time an incident occurs that results in an aggravation of the patient's condition or a new developing condition.

(7) Results of reexaminations that are performed to evaluate significant changes in a patient's condition, including tests that were positive or deviated from results used to indicate normal findings.

(8) When symbols or abbreviations are used, a key that explains their meanings must accompany each file when requested in writing by the patient or a third party.

(9) Documentation that family history has been evaluated.

History: *2009 c 159 s 35*