

Dr. Erick A. Daes, D.C., P.A.
8955 S.W. 87th Court
Miami, Florida 33176
305-233-5700 305-279-2222

PATIENT INFORMATION

NAME _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE _____ CELL _____

E-MAIL _____

Please print clearly email address.{Your email will not be shared with 3rd parties. It will be used to communicate with you from our office and to send periodic reminders, newsletters and information of interest}

BIRTHDATE _____ AGE _____ SEX _____ STATUS---M S W D

HEIGHT _____ WEIGHT _____

OCCUPATION _____ EMPLOYER _____

WORK TELEPHONE _____

SPOUSE'S NAME _____ BIRTHDATE _____

SPOUSE'S EMPLOYER & PHONE _____

NAMES & AGES OF CHILDREN _____

NAME AND PHONE OF EMERGENCY CONTACT _____

WHO MAY WE THANK FOR REFERRING YOU _____

PRIMARY DOCTOR: _____

INSURANCE INFORMATION

NAME OF COMPANY _____

INSURED NAME AND DATE OF BIRTH _____

GROUP # _____ IDENTIFICATION # _____

*** PLEASE REMEMBER TO GIVE THE FRONT DESK A COPY OF YOUR INSURANCE CARD AND DRIVERS LICENSE**

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PATIENT HISTORY FORM

Patient's Name _____ **Date** _____

REASON(S) FOR VISIT

Please circle all that apply: Work, Sport, Auto Accident, Spinal Pain, Spinal Curvature correction (including Scoliosis), Headaches, Arm and/or Leg pain/sciatica, Back Pain, Muscle Spasms, Preventive Checkup/Care, Misaligned Vertebrae, "Slipped disc" [bulge or herniation], Loss of Strength or feeling in the arm/hand or thigh/leg.

When did the condition begin? _____

Explain what happened _____

How often do you experience your symptoms? Please check one:

Constantly _____ (76-100% of the day) Frequently _____ (51-75% of the day)

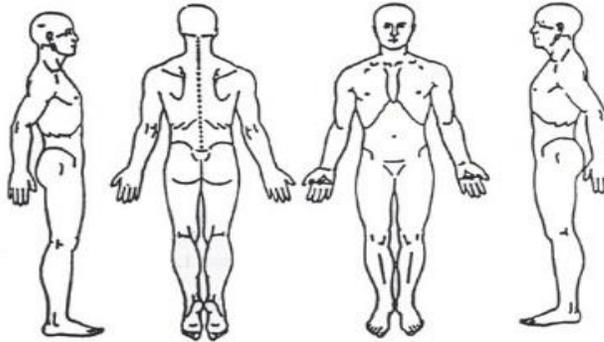
Occasionally _____ (26-50% of the day) Intermittently _____ (0-25% of the day)

What describes the nature of your symptoms?

Sharp _____ Shooting _____ Dull Ache _____ Burning _____ Numb _____ Tingling _____

Mark the appropriate symbol on the picture where you are having pain.

Aching ***** Stabbing ////////////// Numbness ----- Burning XXXXXXX Pins and Needles 000000



Indicate the average intensity of your symptoms: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

How are your symptoms getting? Better _____ Worse _____ Not Changing _____

Has it interfered with your: Work _____ Sleep _____ Daily Routine _____ Recreation _____

Have you ever been treated by a medical physician for this condition? YES _____ NO _____

Have you ever been treated by a chiropractor? YES _____ NO _____

List all medical conditions: _____

List medications/birth control: _____

List major surgeries: _____

Do you have any allergies/asthma? YES _____ NO _____ If so, please list: _____

If female, are you pregnant? YES _____ NO _____ Date of last menstruation _____

Do you smoke? YES _____ NO _____ How much _____

Do you use other substances? YES _____ NO _____

Do you consume alcohol? Never _____ Rarely _____ Occasionally _____ Frequently _____

Signature _____

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Medical History

Please Check and Describe Below any of the following you have had in the last 12 months and/or ever received treatment for:

MUSCULO-SKELETAL Describe Checked Item:

- | | | |
|---|---|------------------------------------|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Arm Pain |
| <input type="checkbox"/> General Stiffness | <input type="checkbox"/> Difficult Chewing/Clicking Jaw | |

GENITO-URINARY

- | | | |
|--|---|--|
| <input type="checkbox"/> Painful/Excessive Urination | <input type="checkbox"/> Discolored Urine | <input type="checkbox"/> Bladder Trouble |
|--|---|--|

CARDIO-VASCULAR-RESPIRATORY

- | | | |
|--|---|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Short Breath | <input type="checkbox"/> Blood Pressure Problems |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Lung Problems/Congestion |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Stroke |

NERVOUS SYSTEM

- | | | | |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Numbness | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Confusion/Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Cold/Tingling Extremities | <input type="checkbox"/> Stress | <input type="checkbox"/> Hearing Difficulty | |

EYES, EARS, NOSE, THROAT

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Stuffed Nose | |

GENERAL

- | | | | |
|-----------------------------------|------------------------------------|------------------------------------|--------------------------------|
| <input type="checkbox"/> Fatigues | <input type="checkbox"/> Allergies | <input type="checkbox"/> Headaches | <input type="checkbox"/> Fever |
|-----------------------------------|------------------------------------|------------------------------------|--------------------------------|

MALE/FEMALE

- | | | |
|---|--|---|
| <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Vaginal Pain/Infection |
| <input type="checkbox"/> Breast Pain/Lumps | <input type="checkbox"/> Prostate/Sexual Dysfunction | <input type="checkbox"/> Other: _____ |

GASTRO-INTESTINAL

- | | | |
|--|--|---|
| <input type="checkbox"/> Poor/Excessive Appetite | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Frequent Nausea |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Gall Bladder Problems |
| <input type="checkbox"/> Weight Trouble | <input type="checkbox"/> Abdominal Cramps | <input type="checkbox"/> Gas/Bloating after meals |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Black/Bloody Stools | <input type="checkbox"/> Colitis |

DESCRIBE ABOVE CHECKED ITEMS:

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT NAME: _____
PATIENT SIGNATURE: _____

Doctor Initials: _____
 Date: _____

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Automobile Accident History

Patient's Name _____ Today's Date _____

Patient's Phone (____) _____

Date of Birth _____ Age _____ Height _____ Weight _____ Sex: M F

Where did the accident occur: City, State, Intersection _____

Date of Accident / Injury _____

Number of people in your vehicle _____ Number of people in other vehicle(s) _____

1. Was the accident on the job? _____ Yes _____ No

2. Where were you seated in the vehicle? _____ Driver _____ Front seat pass. _____ Rea seat pass.

3. What direction were you headed? _____ N _____ S _____ E _____ W

What direction was the other car headed? _____ N _____ S _____ E _____ W

4. **Your vehicle:** Make _____ Model _____ Year _____

Estimated speed upon impact: _____ Stopped _____ Slowing _____ Accelerating _____

If stopped, was your/driver's foot on the brake? _____ Yes _____ No

5. **Other vehicle:** Make _____ Model _____ Year _____

Estimated speed upon impact: _____ Stopped _____ Slowing _____ Accelerating _____

6. **Road conditions at the time of the accident** _____ Dry _____ Wet _____ Other

7. **Time of day** _____ Daylight _____ Dawn _____ Dusk _____ Dark

8. Head restraints, seat backs

Was the headrest positioned properly _____ Yes _____ No

If adjustable, was the position of the headrest altered by the accident? _____ Yes _____ No

Was the seatback adjustment altered by the accident? _____ Yes _____ No

Was the seat broken? _____ Yes _____ No

9. Seat belts and Air bags

Were you wearing a seat restraint? _____ Yes _____ No _____ Don't know

What type? _____ Lap belt _____ Shoulder seat belt _____ Shoulder-lap seat belt

Did your airbag deploy? _____ Yes _____ No

If yes, were you stuck? _____ Yes _____ No Where? _____

10. Head and Body Position

Which way was your **body** pointed at the point of impact?

_____ Straight _____ Right _____ Left. Other (describe) _____

Which way was your **head** pointed at the point of impact?

_____ Straight _____ Right _____ Left. Other (describe) _____

11. During the Crash

Position of hands: _____ One on the wheel _____ Two on the wheel _____ N/A

Did you strike any part of the vehicle? _____ Yes _____ No

If yes, please describe: _____

Did vehicle strike any objects after the crash? _____ Yes _____ No

If yes, please describe: _____

Were you aware or surprised of the approaching collision? _____ Aware _____ Surprised

Did you lose consciousness (black out) upon impact? _____ No _____ Yes how long? _____

12. After the crash

Did you become _____ confused _____ disoriented _____ light headed _____ Dizzy

Are you suffering from _____ restlessness _____ irritable _____ forgetful _____ sleeplessness

Did the police come to the accident _____ Yes _____ No

Is there a report _____ Yes _____ No

Patient Name: _____ Date: _____

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BOURNEMOUTH QUESTIONNAIRE FOR NECK PAIN:

The following scaled have been designed to find out about you Neck pain and how it is affecting you. Please answer ALL the scaled by **CIRCLING ONE** number on EACH scale that best described how you feel:

1. Over the past week, on average how would you rate your Neck pain?
No pain **0 1 2 3 4 5 6 7 8 9 10** Worst pain possible

2. Over the past week, how much has your Neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?
No interference **0 1 2 3 4 5 6 7 8 9 10** Unable to carry out activities
Please Describe: _____

3. Over the past week, how much has your Neck pain interfered with your ability to take part in recreational, social, and family activities?
No interference **0 1 2 3 4 5 6 7 8 9 10** Unable to carry out activities
Please Describe: _____

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/ relaxing) have you been feeling?
Not at all anxious **0 1 2 3 4 5 6 7 8 9 10** Extremely anxious

5. Over the past week, how depressed (down-in-the-dumps, sad, low in spirits, pessimistic, unhappy) have you been feeling?
Not at all depressed **0 1 2 3 4 5 6 7 8 9 10** Extremely depressed

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your Neck?
Made it no worse **0 1 2 3 4 5 6 7 8 9 10** Made it much worse
If worse, which activities? _____

7. Over the past week, how much have you been able to control (reduce/help) your Neck pain on your own?
Completely control it **0 1 2 3 4 5 6 7 8 9 10** No control whatsoever
What have you done? _____

Patient Name: _____

Date: _____

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BOURNEMOUTH QUESTIONNAIRE FOR LOW BACK PAIN:

The following scaled have been designed to find out about you Low Back pain and how it is affecting you. Please answer ALL the scaled by **CIRCLING ONE** number on EACH scale that best described how you feel:

1. Over the past week, on average how would you rate your Low Back pain?
No pain **0 1 2 3 4 5 6 7 8 9 10** Worst pain possible

2. Over the past week, how much has your Low Back pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?
No interference **0 1 2 3 4 5 6 7 8 9 10** Unable to carry out activities
Please Describe: _____

3. Over the past week, how much has your Low Back pain interfered with your ability to take part in recreational, social, and family activities?
No interference **0 1 2 3 4 5 6 7 8 9 10** Unable to carry out activities
Please Describe: _____

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/ relaxing) have you been feeling?
Not at all anxious **0 1 2 3 4 5 6 7 8 9 10** Extremely anxious

5. Over the past week, how depressed (down-in-the-dumps, sad, low in spirits, pessimistic, unhappy) have you been feeling?
Not at all depressed **0 1 2 3 4 5 6 7 8 9 10** Extremely depressed

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your Low Back?
Made it no worse **0 1 2 3 4 5 6 7 8 9 10** Made it much worse
If worse, which activities? _____

7. Over the past week, how much have you been able to control (reduce/help) your Low Back pain on your own?
Completely control it **0 1 2 3 4 5 6 7 8 9 10** No control whatsoever
What have you done? _____

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Patient Name: _____ **Date:** _____

The therapist in our office is performing the techniques described below to perform manual therapy, not traditional massage. Manual therapy is accomplished by hand or with use of instrument(s).

Manual Therapy (CPT 97140) describes multiple manually applied services, including manual traction, myofascial release, joint mobilization, soft tissue mobilization, connective tissue massage, manual lymphatic drainage, and manipulation (non-chiropractic). For myofascial release work, the targeted region(s) is targeted to a specific muscle or other soft tissue. Findings generally involve an adhesion or area of fibrosis exhibited by a painful band or “knot” within the muscle and subsequent limited range of motion. This code describes manually applied techniques that increase active pain-free range of motion and increase extensibility of myofascial tissue, with the goal of restoring function of the muscle or soft tissue. The specific technique is general described as active, passive, or both. Active or passive indicates the methods of stretching or elongation of the soft tissue. I acknowledge this has been explained to me and the therapist is performing the procedure stated above.

Signature

Printed Name

Date

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Patient Consent for Use of Disclosure of Protected Health Information

I give my consent for the above Doctors to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations. (TPO)

Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The above stated Doctors reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Private Practices may be obtained by forwarding a written request to the above stated Doctors.

With this consent, the above stated Doctors may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the above Doctors may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, and patient statements as they are marked Personal and Confidential.

With this consent, the above stated Doctors may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the above stated Doctors' use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the above stated Doctors may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print name of Patient or Legal Guardian

Date

NOTICE OF EMERGENCY MEDICAL CONDITION

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The undersigned **licensed medical provider**, hereby asserts:

1. The below patient, has in the opinion of this medical provider, suffered an **Emergency Medical Condition**, as a result of the patient's injuries sustained in an automobile accident that occurred on _____ (fill in date of accident).
2. The basis of the opinion for finding an **Emergency Medical Condition** is that the patient has sustained acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: a) serious jeopardy to patient health b) serious impairment to bodily functions or c) serious dysfunction of a bodily organ or part.

I hereby attest that I am a physician licensed under Chapter 458 or Chapter 459, a dentist licensed under Chapter 466, a physician assistant licensed under Chapter 458 or Chapter 459, or an advanced registered nurse practitioner licensed under Chapter 464, and that the above facts are true and correct.

NAME (PRINT OR TYPE)	Signature of Medical Provider	DATE
----------------------	--------------------------------------	------

The undersigned **injured person** or legal guardian of such person asserts:

1. The symptoms I reported to the medical provider are true and accurate.
2. I understand the medical provider has determined I sustained an Emergency Medical Condition as a result of the injuries I suffered in the car accident.
3. The medical provider has explained to my satisfaction the need for future medical attention and the harmful consequences to my health which may occur if I do not receive future treatment.

Injured patient receive this diagnosis or legal guardian of said injured patient:

NAME (PRINT OR TYPE)	Signature of Injured Patient/Guardian	DATE
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Assignment of Insurance, Benefits, Power of Attorney and Release of Information

Insurer Please Read the Following, in its Entirety, upon Receipt

Dr. Erick A. Daes, D.C., P.A.

8955 S.W. 87th Court
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I, the undersigned patient/insured, _____ (print name of patient/insured or parent/guardian if patient is a minor), knowingly, voluntarily and intentionally **assign the benefits** of insurance and any overdue interest payments under the No-Fault Policy of Automobile insurance, also known as Personal Injury Protection (P.I.P.), or Medical Payments policy of insurance from my automobile insurer or the responsible insurer to the above described medical provider or any and all services rendered to the undersigned patient/insured. It is the intent of this medical provider to accept this assignment-of benefits. The undersigned also assigns any and all claims for statutory bad faith to the above medical provider. The undersigned patient/insured directs the insurer to pay the medical provider directly. The insurer is further directed by the provider and the patient to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer from liability unless there has been a prior written settlement agreed to by the medical provider and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments made at the discretion of the insurer. Any partial or reduced payment issued by the insurer and deposited by the provider shall be done so under protest and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. In the event the subject medical benefits are disputed for any reason, including but not limited to, medical reasonableness and /or necessity, the undersigned patient/insured hereby instructs the insurer to set aside any amount disputed (i.e. to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. Any partial payment, regardless of the accompanying language, will be deemed a partial payment and the insured will be making the payment at its own risk unless there is a prior written settlement agreed to by this provider. I hereby instruct the insurer to notify the above provider immediately of any dispute. If the insurer schedules an IME or EUO the insurer is hereby requested and authorized to send a copy of said notification to this provider. The provider is not the agent of the insurer or the patient for any purpose. The undersigned patient/insured agrees to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts, and for any other services unrelated to the automobile accident. I understand this assignment will remain in full force and effect and will **NOT** be revoked unless the revocation is agreed to by both the medical provider **AND** the undersigned patient or the patient's attorney. This assignment applies to both past and future medical expenses and is valid even if undated or if not signed by provider. The patient understands it is the express intention of the provider to accept this assignment of benefit in lieu of demanding payment at the time services are rendered. A photocopy of this assignment is to be considered as valid as the original.

Power of Attorney I also agree the above provider is hereby given the power of attorney to sign my name on any checks for payment for services rendered by the above provider.

Release of Information I hereby authorize this medical provider to furnish my insurance company or companies and the patient's attorney with any and all information that may be contained in my medical records and to request a copy of my POP payout sheet from the insurer. I also hereby authorize this medical provider to obtain copies of my medical records, including but not limited to documents, reports, scans, notes, opinions, X-rays, and MRI's, from any other medical provider or any insurance company. The insurer is directed to keep the patient's medical records private and confidential. The insurer is NOT authorized to provide these medical records to anyone, including but not limited to third party vendors without the patient's and the provider's prior express written permission.

Caution! Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the terms.

Patient's Signature _____
(If patient is a minor, signature of parent/guardian)

Date _____

Medical Provider's Signature _____

Date _____

--Any person, who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information may be guilty of a felony of the third degree.

I understand the information on all forms and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes in my medical status.

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I authorize the staff to perform any necessary services during the diagnosis and treatment. I also authorize the provider and/or managed care organizer to release any information required to process insurance claims.

I authorize Dr. Erick A. Daes to provide medical services to me.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees and any other expenses incurred in collection your account. I understand that I am financially responsible for all changes whether or not paid by the insurance companies.

I authorize the release of any medical information necessary to process this claim including but not limited to all of my insurance companies. I also request payment of government benefit either to myself or to the party who accepts assignments below.

Signature on File:

I authorize payment of medical benefits to the undersigned physician(s) or supplier of service. I authorize physician to act as my agent in helping me obtain payment from my insurance companies. I authorize payment directly to my physician. I permit a copy of this authorization to be used in place of my original signature. I authorize use of this form on all my insurance submissions.

Patient's Signature

Date

Doctor's Signature

Date

Date _____

To: Attorney

Dr. Erick A. Daes, D.C., P.A.

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I have had the opportunity to discuss with the doctor and/or with other office or clinical personnel the purpose and benefits of Manipulations (adjustments) and other treatments outlined below. Alternatives to treatments have been reviewed.

I understand that I will be receiving one or more of the following treatments: Manipulations (adjustments), Mobilization Therapy, Hot/Cold Packs, Electrical Stimulation, Inferential Current, Myofascial Release, Traction, Therapeutic Exercises, Massage, Spinal Decompression, Mechanical Traction, Passive Mobilization, Taping or Splinting.

I understand that Manipulation (adjustments) is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding treatment that I have requested or authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient (or guardian)

Date

Doctors Signature

Date

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THERAPY NOTES

Myofascial trigger point (MFTP) release can be light and/or deep. It is accomplished by relaxing contracted muscles and fascia, and increasing circulation and lymphatic drainage. It is accomplished with the use of knuckles, elbows, or tools (instrument assisted, IAM) to slowly stretch the restricted myofascial structures and elongation of fascia and adhesive tissues. This causes an increase in range of motion and softening of the hypertonic tissues.

<u>DATE</u>	<u>PERFORMED BY</u>	<u>AREAS/ MUSCLES TREATED</u>					<u>TIME (min.)</u>	
_____	_____	Group #	1	2	3	4	5	_____
_____	_____	Group #	1	2	3	4	5	_____
_____	_____	Group #	1	2	3	4	5	_____
_____	_____	Group #	1	2	3	4	5	_____
_____	_____	Group #	1	2	3	4	5	_____
_____	_____	Group #	1	2	3	4	5	_____
_____	_____	Group #	1	2	3	4	5	_____
_____	_____	Group #	1	2	3	4	5	_____
_____	_____	Group #	1	2	3	4	5	_____
_____	_____	Group #	1	2	3	4	5	_____
_____	_____	Group #	1	2	3	4	5	_____
_____	_____	Group #	1	2	3	4	5	_____
_____	_____	Group #	1	2	3	4	5	_____
_____	_____	Group #	1	2	3	4	5	_____
_____	_____	Group #	1	2	3	4	5	_____

GROUP #

1. **Cervical group includes:** occipital fibers, scalenes, cervical paraspinals, trapezius, levator scapula rhomboid muscles.
2. **Shoulder group includes:** supra/infraspinatus, teres, rhomboids, deltoid, trapezius, levator scapula, pectoralis muscles.
3. **Dorsal group includes:** dorsal paraspinal muscles, trapezius, rhomboids, serratus, latissimus muscles.
4. **Lumbar group includes:** lumbar paraspinals/erector spinae, quadratus lumborum, lumbar fascia.
5. **Pelvic group includes:** piriformis, gluteals, TFL muscles, sacrotuberous ligament.

Patient Name _____ Sign _____ Date _____