

Technical Support Guide

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1.0 ChiroWrite Overview

ChiroWrite is the world's first Chiropractic reporting system designed with the Tablet PC component, however, the system can be used on a desktop computer, laptop computer, or touch screen monitor. Doctors will be able to conduct physical examinations and complete forms and questionnaires in real time for their patients.

ChiroWrite allows the doctor an easy way to record patient visits and exams so that SOAP Notes and Narratives can be easily produced. The software consists of all the medical questionnaires and forms that a chiropractor uses on a routine basis when conducting physical examinations. The system also has the ability to produce a comprehensive list of required reports based on the information input into the system.



Security

1.1 Security and Encryption

ChiroWrite uses a SHA-1 hashing algorithm at 160-bits to check the integrity of information. This assists in determining if information has been altered prior to receipt. ChiroWrite also uses the Advanced Encryption Standard (AES) which is a symmetric-key encryption in a 128-bit block used to safeguard information. ChiroWrite uses the CBC cipher mode and encodes the information using HEX codes.

2.0 Administration QuickStart Guide

The QuickStart Setup Guide allows you to customize the most popular areas of the system, WorxPhrases and Treatments, but it is recommended that you take the time to go through all the available customization options that the program offers to obtain the largest benefit from the system.

System Login WorxPhrases Creating a New WorxPhrase Edit an Existing WorxPhrase Add a WorxPhrase Category Edit a WorxPhrase Category Change the Order of the WorxPhrases WorxPhrase Symbols Sharing WorxPhrases Getting Shared WorxPhrases Treatments Change the Order of Treatments Create a Treatment Edit a Treatment **Treatment Areas** Changing the Order of Treatment Areas Create a Treatment Area Edit a Treatment Area **Backup/Restore Configuration**

2.1 ChiroWrite System Login

Once you start the Softworx ChiroWrite program you will see the login screen as shown below.

1. Enter your Login ID and Password, if you have already created one. Otherwise simply click the Login button.



2. Click the Login button.

Tip: To create a user name and password for employees, select Administration and Employees and refer to section 3.2.16 for further information.

2.2 WorxPhrase

WorxPhrase allows you to configure standard sentences and/or paragraphs that you use often and store them for quick retrieval. An example of what WorxPhrase can do for you is that if you had a sentence, such as, "is complaining of lower back pain. feels this pain after any moderate activity" the system would convert that information to "Mr. Smith is complaining of lower back pain. He feels this pain after any moderate activity." The WorxPhrase function can greatly reduce the amount of typing that has to be performed.

2.2.1 Create a New WorxPhrase

- 1. Select Administration > WorxPhrase.
- 2. Click the New button.
- 3. Select the Area drop down menu and make your selection.
- 4. Select the Category.
- 5. Enter the **Code**.

Tip: WorxPhrases should be typed in complete sentences.

6. Type the custom phrase. You can also utilize the Available Variables by clicking on the blue link to automatically insert that item into the phrase.



2.2.2 Edit an Existing WorxPhrase

1. Choose Administration > WorxPhrase.

- 2. Highlight the phrase to edit.
- 3. Click Edit to display the Edit Existing Phrase window.

4. The Phrase can be rewritten to meet your needs. You can also use the Available Variable links in the window so that when reports are run the items are automatically inserted for that patient.

Tip: WorxPhrases should be typed in complete sentences.

DB	Area:	Accident Descrip	ption	
	Category:			
Save	Code:	MVA-D		
Close	Phrase:	<titlelastname restrained driver stop at a traffic li</titlelastname 	> stated that <he she=""> was the of <his her=""> car and had come to a ght.</his></he>	0
	Available Val	Tables:	< FirstName>	
	First Nd	ast Name	<firstlastname></firstlastname>	
	Title & I	ast Name	<titlelastname></titlelastname>	
	His/Her	(upper case)	<his her=""></his>	
	He/She	(upper case)	<he she=""></he>	
	his/her (lower case)	<his her=""></his>	
	he/she (lower case)	<he she=""></he>	
	him/her	(lower case)	<him her=""></him>	
	Ex: <titlela< td=""><td>stName> is compla</td><td>ining of lower back pain.</td><td></td></titlela<>	stName> is compla	ining of lower back pain.	
	Mr Co	with is complaining o	f lower back pain	

- 5. Select the Save button.
- 6. Click Close.

2.2.3 Add a WorxPhrase Category

WorxPhrase categories are used to break up many different phrases that may be added to one area so that the phrases are easier to find.

- 1. Select Administration > WorxPhrase.
- 2. Highlight a phrase and click the **Category** button.
- 3. The WorxPhrase Categories window appears. Select the New button.
- 4. Enter a new Description in the Add New CPT Category window.

🚽 Add New	CPT Category		? 🗙
Bave	Description:	Sub Category 5	
Close			

- 5. Select the Save button.
- 6. Click Close.

2.2.4 Edit a WorxPhrase Category

- 1. Select Administration > WorxPhrase.
- 2. Highlight the phrase and click the Edit button.

Phrases			-9-
	Area	Code	Phrase
X	Accident Description	MVA	The patient reported that <he she=""> was involved</he>
Close	Accident Description	MVA-D	<titlelastname> stated that <he she=""> was the n</he></titlelastname>
	Accident Description	MVA-DZY	Shortly after the accident <titlelastname> repor</titlelastname>
	Accident Description	LB&SHOU	As a result of the accident, the patient reported th
New	Accident Description	MVA-WHPLSH	Upon impact, the patient's head and neck went th
0.0000	Accident Description	MVA-PSNG	<titlelastname> reports that <he she=""> was a re</he></titlelastname>
	Accident Description	MVA-U-PSNG	<titlelastname> reports that <he she=""> was an i</he></titlelastname>
Edit	Accident Description	MVA-TRNSP	The patient was taken in an ambulance to the en
Cun	Accident Description	XRAY-CRV-T	X-rays were taken of <his her=""> cervical and thora</his>
	Accident Description	PI	<titlelastname> stated that <he she=""> was injure</he></titlelastname>
	Assessment - Other		In my opinion the patient's symptoms are progre-
	Chief Complaint	LBP	<firstname> patient complains of lower back pa</firstname>
	Chief Complaint	RSP	The patient is complaining of intermittent right sh
Category	Chief Complaint	PSS-LB	<he she=""> also complains of of having pain with</he>
	Chief Complaint	LBP	<titlelastname> is complaining of lower back p</titlelastname>
	Chief Complaint	SHOU-LFT	The patient is complaining of intermittent left sho
Share	Chief Complaint	LB-RHT	On the right side of <his her=""> lower back, <he sh<="" td=""></he></his>
Selected	Chief Complaint	LFT-4ARm	The patient complains that <he she=""> has numbre</he>
	Chief Complaint	SHOU-RHT	The patient is complaining of intermittent left shore
Get	Chief Complaint	CERV-R	The patient is complaining of constant pain in the
Shared	Chief Complaint	CERV-L	The patient is complaining of constant pain in the *
Prilases	•		

- 3. Make the necessary changes to the WorxPhrase Category window.
- 4. Select the **Save** button.
- 5. Click Close.

2.2.5 Change the Order of WorxPhrases

- 1. Select Administration > WorxPhrase.
- 2. Highlight the phrase and click the **Category** button.

3. Highlight the WorxPhrase Category and click the Up or Down buttons to move the category into the desired position.

🖳 WorxPhrase	e Categories	? *
X	Description Sub Category 2	
Close	Sub Category 3	
	Sub Category 4	
	DLA	
New		
Edit		
Up		
Down		

4. Select Close.

2.2.6 WorxPhrase Symbols

WorxPhrase Symbols allow you to interact with the system to have the system ask you for additional information that may be patient specific. Reviewing the <u>Dynamic Lists Video</u> will provide you with a better idea of how Worxphrases may be helpful throughout ChiroWrite. These lists can also be used in the prognosis, narrative introduction and narrative ending sections. Watch the WorxPhrase Symbols Added to Prognosis, Narrative Intro and Narrative Ending for more details.

1. We can have the system ask us for numbers using **##Title##**. Below is an example.

<FirstLastName> is only able to sit for ##CurrentMin## minutes and I want <him/her> to be able to sit for ##PlanMin## minutes.

2. The screen below will pop up to ask you to input whichever number you are requesting.



3. We can have the system ask us for items that are part of a list using **^Title^listItem^listItem^^**. Below is an example.

<FirstLastName> is only able to ^^Activity^sit^walk^stand^run^jog^^ for ##CurrentMin## minutes and I want <him/her> to be able to ^^Activity^sit^walk^stand^run^jog^^ for ##PlanMin## minutes.

4. The screen below will pop up to ask you to select items from whichever list you have pre-defined.

🚽 WorxPhr	seSubstituter	
Tag:	Activity	
sit		
walk		
stand		
run		
jog		
1		
Start	Over	Finished

- 5. Select **Save** when changes are complete.
- 6. Click Close.

2.2.7 Sharing WorxPhrases

1. To share WorxPhrases select Administration > WorxPhrase.

Area		
	Code	Phrase
Accident Description	MVA	The patient reported that <he she=""> was involved</he>
Accident Description	MVA-D	<titlelastname> stated that <he she=""> was the r</he></titlelastname>
Accident Description	MVA-DZY	Shortly after the accident <titlelastname> repor</titlelastname>
Accident Description	LB&SHOU	As a result of the accident, the patient reported th
Accident Description	MVA-WHPLSH	Upon impact, the patient's head and neck went th
Accident Description	MVA-PSNG	<titlelastname> reports that <he she=""> was a re-</he></titlelastname>
Accident Description	MVA-U-PSNG	<titlelastname> reports that <he she=""> was an i</he></titlelastname>
Accident Description	MVA-TRNSP	The patient was taken in an ambulance to the em
Accident Description	XRAY-CRV-T	X-rays were taken of <his her=""> cervical and thora</his>
Accident Description	PI	<titlelastname> stated that <he she=""> was injure</he></titlelastname>
Assessment - Other		In my opinion the patient's symptoms are progree
Chief Complaint	LBP	<firstname> patient complains of lower back pa</firstname>
Chief Complaint	RSP	The patient is complaining of intermittent right sh
Chief Complaint	PSS-LB	<he she=""> also complains of of having pain with</he>
Chief Complaint	LBP	<titlelastname> is complaining of lower back p</titlelastname>
Chief Complaint	SHOU-LFT	The patient is complaining of intermittent left sho
Chief Complaint	LB-RHT	On the right side of <his her=""> lower back, <he sh<="" td=""></he></his>
Chief Complaint	LFT-4ARm	The patient complains that <he she=""> has numbre</he>
Chief Complaint	SHOU-RHT	The patient is complaining of intermittent left shore
Chief Complaint	CERV-R	The patient is complaining of constant pain in the
Chief Complaint	CERV-L	The patient is complaining of constant pain in the
	Accident Description Accident	Accident Description MVA-D Accident Description MVA-D Accident Description LB&SHOU Accident Description MVA-DZY Accident Description MVA-WHPLSH Accident Description MVA-PSNG Accident Description MVA-PSNG Accident Description MVA-PSNG Accident Description MVA-UPSNG Accident Description MVA-TRNSP Accident Description MVA-TRNSP Accident Description MVA-TRNSP Accident Description MVA-TRNSP Accident Description PI Assessment - Other Chief Complaint Chief Complaint LBP Chief Complaint LBP Chief Complaint LBP Chief Complaint LB-RHT Chief Complaint LFT-4ARm Chief Complaint SHOU-RHT Chief Complaint CERV-R Chief Complaint CERV-R Chief Complaint CERV-R Chief Complaint CERV-R

- 2. Select the WorxPhrase you wish to share and click Share Selected.
- 3. You will be prompted to add a message if you wish, otherwise click Add Phrase.
- 4. When finished click **Close**.

2.2.8 Getting Shared WorxPhrases

1. To get shared WorxPhrases select Administration > WorxPhrase.

Phrases			-9-
	Area	Code	Phrase
	Accident Description	MVA	The patient reported that <he she=""> was involved</he>
Close	Accident Description	MVA-D	<titlelastname> stated that <he she=""> was the n</he></titlelastname>
	Accident Description	MVA-DZY	Shortly after the accident <titlelastname> repor</titlelastname>
	Accident Description	LB&SHOU	As a result of the accident, the patient reported th
New	Accident Description	MVA-WHPLSH	Upon impact, the patient's head and neck went th
1002000V	Accident Description	MVA-PSNG	<titlelastname> reports that <he she=""> was a re-</he></titlelastname>
	Accident Description	MVA-U-PSNG	<titlelastname> reports that <he she=""> was an i</he></titlelastname>
E-O	Accident Description	MVA-TRNSP	The patient was taken in an ambulance to the em
Cun	Accident Description	XRAY-CRV-T	X-rays were taken of <his her=""> cervical and thora</his>
	Accident Description	PI	<titlelastname> stated that <he she=""> was injure</he></titlelastname>
	Assessment - Other		In my opinion the patient's symptoms are progree
	Chief Complaint	LBP	<firstname> patient complains of lower back pa</firstname>
	Chief Complaint	RSP	The patient is complaining of intermittent right sh
Category	Chief Complaint	PSS-LB	<he she=""> also complains of of having pain with</he>
	Chief Complaint	LBP	<titlelastname> is complaining of lower back p</titlelastname>
_	Chief Complaint	SHOU-LFT	The patient is complaining of intermittent left sho
Share Selected	Chief Complaint	LB-RHT	On the right side of <his her=""> lower back, <he sh<="" td=""></he></his>
	Chief Complaint	LFT-4ARm	The patient complains that <he she=""> has numbro</he>
	Chief Complaint	SHOU-RHT	The patient is complaining of intermittent left sho
Get	Chief Complaint	CERV-R	The patient is complaining of constant pain in the
Shared Phrases	Chief Complaint	CERV-L	The patient is complaining of constant pain in the

2. Select the Get Shared Phrases button.

	Search Criteria		
X	a View All Contribution	Niew Only M	v Contributions
Close		O YION ONLY IN	y CONTRIDUCTIONS
Ciuse	 View All Areas 	C Limit List To	Specific Area
	Area	Code	Phrase
Search	Accident Description	MVA	The patient reported that <he she=""> was involved in a motor vehi</he>
	Assessment - Exacerbation	lumtencare	In spite of the fact that <firstname> perceived only tightness in</firstname>
	Assessment - Exacerbation	certencare	In spite of the fact that <firstname> perceived only tightness in</firstname>
View	Chief Complaint	CERV-L	The patient is complaining of constant pain in the cervical area
	Final Notes	Based on	Based on orthopedic, neurological and physical exams plus cas
	Final Notes	AMA	It was noted on the discharge exam the patient has a permanent
tolect	Final Notes	DRE	Diagnosis Related Estimates (DRE) category III were used in th
~~~~	Final Notes	ad-living	Additionally, the Guides state, "If residual symptoms or objective
	Final Notes	Based 2	Based on the parameters and guidelines, the patient has a 18%
	Final Notes	FutureCare	The patient is now prone to complication or exacerbations they
	Final Notes	Perjury	I declare under penalty of perjury that the information contained i
emove	Final Notes	TTD	The patient was totally temporarily disabled from ????.
	Objective	Scope	There is a thermographic temperature differential measured by a
	Plan - Treatment Goals	Goal	The goals of the treatment is to decrease <firstlastname> pai</firstlastname>
	Plan - Treatment Goals	freq	Frequency of treatment will decrease as symptoms improve. Init
	Subjective - Comments	ROF	<firstlastname> returns to the office for report of the doctor's f</firstlastname>

- 3. To view what the WorxPhrase says select the phrase and click View.
- 4. Select the WorxPhrase you want to add to your library and click Select.
- 5. When finished click **Close**.

### 2.3 Treatments

Treatment configurations give you the ability to change the order in which treatments show up to easier access the treatments you perform in your office. You also have the ability to create new treatments that are not already defined in the system and edit pre-existing and created treatments within the system.

### 2.3.1 Change the Order of Treatments

1. Select Administration > Treatment Configuration > Treatments.

🖶 Treatments			7 🔜		
X	Category:				
	Treatment	Category	*		
Close	Ultrasound	Adjunctive Therapy			
	hot packs	Adjunctive Therapy			
New	cold packs	Adjunctive Therapy	=		
	Electrical Stimulation	Adjunctive Therapy			
	Acupuncture	Adjunctive Therapy			
	Iontophoreses	Adjunctive Therapy			
Edit	Neuro-muscular Massage	Adjunctive Therapy			
	Myofascial Release	Adjunctive Therapy			
	Paraffin Bath	Adjunctive Therapy			
	Russian Stimulation	Adjunctive Therapy			
	Spray & Stretch	Adjunctive Therapy			
Up	Tens Unit	Adjunctive Therapy			
	Traction	Adjunctive Therapy			
Down	Diathermy	Adjunctive Therapy			
		· · · ·	•		

2. Limit the list to a specific category, then highlight the treatment and click the **Up** or **Down** to move the treatment into the preferred position.

3. Select Close. Your changes will be automatically saved.

#### 2.3.2 Create a Treatment

- 1. Select Administration > Treatment Configuration > Treatments
- 2. Select the **New** button.
- Tip: Description, Category and Status are required to create a treatment.

🛃 Add New 1	Treatment		
<b>P</b>	Description:		
Save		Print as entered (do not lower case)	
	Category:		-
Close	Purpose/ Goals:		*
		Auto Default on Plan screen	
	Treatment Default:		* *
		Auto Default on Treatment screen	
	CPT Code:		•
	Status:	Active	

- 4. When you are finished entering data, click Save.
- 5. Select the Close button.

## 2.3.3 Edit a Treatment

- 1. Select Administration > Treatment Configuration > Treatments.
- 2. Click the **Edit** button.



- 3. When finished, select Save.
- 4. Select the Close button.

#### 2.4 Treatment Areas

Treatment configurations give you the ability to change the order in which treatment areas show up to easier access the areas you perform treatments on in your office. You also have the ability to create new treatment areas that are not already defined in the system and edit pre-existing and created treatment areas within the system.

1. Select Administration > Treatments > Treatment Areas.

2. Limit the list to a specific category and then highlight the treatment. Click the **Up** or **Down** button to move the treatment area to the desired location.

📲 Treatment	Areas			2 🔀
X	Category:			•
	Treatment	Group	Category	Sequence
Close	Cervical	Cervical	Spine	1
	C0	Cervical	Spine	2
	C1	Cervical	Spine	3
New	C2	Cervical	Spine	4
	C3	Cervical	Spine	5
	C4	Cervical	Spine	6
Edit	C5	Cervical	Spine	7
	C6	Cervical	Spine	8
	C7	Cervical	Spine	9
	Thoracic	Thoracic	Spine	10
Up	11	Thoracic	Spine	11
I ₽	T2	Thoracic	Spine	12
Down	T3	Thoracic	Spine	13
	T4	Thoracie	Snine	14 *

3. Click the Close button

## 2.4.2 Create a Treatment Area

- 1. Select Administration > Treatment Configuration > Treatment Area.
- 2. Click the New button.

Tip: All fields need to be filled in to create a treatment area.

- 3. Enter the Area.
- 4. Select the Category from the drop down menu.
- 5. Select the Group.
- 6. Choose a Status.

Area	a:	Cervic	al		
ave Cate	egory:	Spine	)	•	
Gro	up:	Cervic	al	-	
•		Prin	t as entered	(do not lov	ver case)
se Stat	us:	Active	•	]	
Reg	ion:	1	1 Cervic	al	
			2 Thorac 3 Lumba	sic Ir	
			4 Sacro,	Pelvis, Illu	im, etc.

- 7. If a **region** needs to be chosen because you are linked with a billing system then do so.
- 8. Click Save.
- 9. Click Close.

## 2.4.3 Edit a Treatment Area

- 1. Select Administration > Treatment Configuration > Treatment Area.
- 2. Highlight a treatment area and click Edit.
- 3. Make the necessary changes in the window similar to the one shown below and click Save.

	Area:	Cervi	cal	
Save	Category:	Spine	•	•
-	Group:	Cervi	cal	•
Close	Status:	Active	nt as entered	(do not lower case)
	Region:	1	1 Cervica 2 Thorac 3 Lumbar 4 Sacro, 5 Occipu	al ic r Pelvis, Illuim, etc. t. cranial bones, etc.

4. Select the Close button.





Warning: The software backup function is vital to the successful use of the program. If you have any trouble or need assistance with the backup or system restore, please call 800-642-6082.

1. Select Administration > System Configuration > Backup/Restore.



2. A default path is displayed. If you want to save or restore to or from an alternate location, click the **Browse** button and navigate to the proper location.

- 3. Select either the Backup or the Restore button.
- 4. Click Save.
- 5. Select the Close button.

## 3.0 Menu Items

The menu items located on the top toolbar of the ChiroWrite program are outlined in this chapter. Each topic is broken down into sub chapters to better assist you in searching for a specific topic.

## 3.1 File Menu

The file menu allows you the opportunity to change your system passwords, set the preferences, and performing imports and exports in the system.

### 3.1.1 Change Password



- 2. Enter the old password.
- 3. Enter the new password.
- 4. Re-enter the **new password** for verification purposes.
- 5. Click the Update Pass button.
- 6. Click Close.

## 3.1.2 Preferences

1. Select File > Preferences.

Preferences	5	-7-
Save	Note: Color sche logon. Color Scheme:	eme changes take effect the next time you Summer Day
Close		

2. Select the color scheme you prefer for the ChiroWrite program.

Note: The color scheme will not take effect until after you log back into the system.

The color scheme choices are:

- Autumn Burst
- Storm Clouds
- Summer Days
- Summer Night
- 3. After you have made your selection, click Save.
- 4. Choose Close.

### 3.1.3 Import

1. Select File > Import.

2. Choose the system that you are importing from and follow the on screen instructions. The ChiroWrite system allows the following programs to import data into it:

- Clinic Essentials
- Eclipse
- Ezbis
- Genius
- MediSoft
- LinkRunner
- PMP
- InPhase

#### 3.1.4 Export

- 1. Select File > Eclipse > Billing.
- 2. Follow the instruction prompts to export your data from the Eclipse system.

### 3.2 Administration

Any configuration or customization in ChiroWrite takes place under the Administration section.

#### 3.2.1 WorxFlow

ChiroWrite provides a unique workflow engine, WorxFlow, which allows the doctor to configure the order that the examination and SOAP screens appear while also allowing for the creation of WorxFlow.

If you have a certain group of tests that you would perform for a knee injury and another set of tests for patients with back problems you could configure multiple WorxFlows so that a particular group of tests are available for that particular type of injury instead of all the default tests. This customizable feature reduces the number of items that you go through to complete the examination.

#### 3.2.1.1 Create a New WorxFlow



Warning: If you want to create a new WorxFlow please do so carefully or contact technical support for assistance at 800-642-6082. Please do not change the Standard Template or the SOAP Template try to create a new WorxFlows as you could severely damage your system.

#### 1. Select Administration > WorxFlow.



#### 2. Select the New button.



- 3. Type in a **WorxFlow name**.
- 4. Click the **Close** button.
- 5. Select the **WorxFlow** from the list and Click the **Edit** button.

e Wondlows		-?
	Sequence	Name
	1	Standard Template
Close	2	SOAP
	3	Detailed Template
New	4	Spinal Exam
	5	Outcome Assessment
	6	SOAP Light
Edit	7	Softworx
Lon	8	Test Workflow
	9	Dr.G Test
	10	Test
Up	11	Knee Exam
	12	Example
Down		
Screens		

6. Click the New button to create a new category. Do Not Change the Examination or SOAP categories.



7. Type a **new category** in the category name space.



8. Click the **close** button.



9. Select the category and click the edit button.

10. Select a screen from the available windows and use the left and right arrows to move things in and out of the WorxFlow.

e Wonflow (	lategory Items				- ? <b>- X</b>
X	Category Name:	Example			
Close	Selected Windows			Available Windows	
	Sequence Item Name			Item Name	<u>^</u>
				Ambulation	E
				Assessment	
				Body Picture	
•				Cervical Spine	
			(2)	Cervical Spine Picture	
Up				Changing Degree Of Pain	
				Charges	
Down				Communication	
				Complaints	
				Concentration	
				Diagnosis	
				Diagnostic Requests	
				Driving	
				Exam Custom 1	-
	Item Description:				
					*
					*

- 11. You can move items up or down in the list, if needed, using the Up and Down arrows.
- 12. Close out of ChiroWrite to see changes you have made to the WorxFlows.

#### 3.2.1.2 Edit an Existing WorxFlow

The ChiroWrite program allows you to customize the order of the Worxflows. You can also add, edit, remove, or move the categories in a Worxflow to meet your needs. Please only edit Worxflows you have created or the Spinal Exam Template only!



Warning: If you want to create a new WorxFlow please do so carefully or contact technical support for assistance at 800-642-6082. Please do not change the Standard Template or the SOAP Template try to create a new WorxFlows as you could severely damage your system.

#### 1. Select Administration > WorxFlow.

🖳 Wonflows		- 2 - <b>- 2</b> -
	Sequence	Name
	1	Standard Template
Close	2	SOAP
	3	Detailed Template
New	4	Spinal Exam
	5	Outcome Assessment
	6	SOAP Light
Edit	7	Softworx
Lun	8	Test Workflow
	9	Dr.G Test
	10	Test
Up	11	Knee Exam
	12	Example
Down		
Screens		

#### 2. Select the Edit button.



3. Select the category and click the edit button.



4. Select a screen from the available windows and use the left and right arrows to move things in and out of the WorxFlow.

X	Category Name: Example			
lose	Selected Windows	Available Windows		
	Sequence Item Name	Item Name		
		Ambulation	1	
		Assessment		
		Body Picture		
•		Cervical Spine		
✿		Cervical Spine Picture	3	
Up		Changing Degree Of F	Pain	
		Charges		
own		Communication		
		Complaints		
		Concentration		
		Diagnosis		
		Diagnostic Requests		
		Driving		
		Exam Custom 1		
	Item Description:			

- 5. You can move items up or down in the list, if needed, using the Up and Down arrows.
- 6. Close out of ChiroWrite to see changes you have made to the WorxFlows.

#### 3.2.1.3 Changing the Order of the WorxFlow

The WorxFlow system comes with several predefined WorxFlows. The steps outlined below will assist you in changing the order of the WorxFlows to organize them as you wish them to appear.

1. Select Administration > WorxFlow from the top menu bar.

P Worxflows		
	Sequence	Name
	1	Standard Template
Close	2	SOAP
	3	Detailed Template
New	4	Spinal Exam
	5	Outcome Assessment
	6	Test Flow A
Edit	7	Lumbar Exam
Up		
Down		

- 2. Highlight the name of the WorxFlow and select the Up or Down buttons to change the order.
- 3. Click the Close button when finished.

Each WorxFlow is made up of one or more categories. The WorxFlow system comes with predefined WorxFlows that are comprised of multiple categories. The steps outlined below will assist you with adding an existing category to one of the WorxFlows in the system.

#### 1. Select Administration > WorxFlow

2. Highlight the WorxFlow and click Edit to launch the WorxFlow Categories.

🛃 Wonflow C	ategories			7 🔀
X	Worxflow Name:	Lumbar Exam		
Close	Selected		Available	
	Sequence Categ	ory Name	Category Name	<u> </u>
			Daily Living Assesment	
New			Exam	
			Exam A	
			Examination	E
Edit			Finalize	
			Knee Tests	
			Lumbar Tests	
			Mensuration Circumferentia	
			Muscle Testing (Kendall's)	
			Neck Disability Index	
			Neurological Testing	
			Orthopedic Evaluation	
			Oswestry Low Back	
Down			Patient Complaints	-

3. Highlight a Category name on the right side under the **Available window** and click the Left arrow to move it to the **Selected window**.

4. Click Close when finished. Any changes made will be automatically saved.

### 3.2.1.5 Edit an Existing Category to a WorxFlow

Each WorxFlow is made up of one or more categories. The WorxFlow system comes with predefined WorxFlows that are comprised of multiple categories. The steps outlined below will assist you with adding an existing category to one of the WorxFlows in the system.

#### 1. Select Administration > WorxFlow

2. Highlight the WorxFlow and click Edit to launch the WorxFlow Categories.

🛃 Wonflow C	ategories			7 🔜
X	Worxflow Name:	Lumbar Exam		
Close	Selected		Available	
	Sequence Categ	ory Name	Category Name	<u> </u>
			Daily Living Assesment	
New			Exam	
			Exam A	
			Examination	E
Edit			Finalize	
			Knee Tests	
			Lumbar Tests	
			Mensuration Circumferential	
			Muscle Testing (Kendall's)	
			Neck Disability Index	
1			Neurological Testing	
Op			Orthopedic Evaluation	
			Oswestry Low Back	
Down			Patient Complaints	-

3. Highlight a Category name on the right side under the **Available window** and click the Left arrow to move it to the **Selected window**.

4. Click Close when finished. Any changes made will be automatically saved.

#### 3.2.1.6 Remove a Category from the WorxFlow

The WorxFlow system comes with seven predefined WorxFlows that are comprised of multiple categories. The steps outlined below will assist you with removing a category from one of the seven WorxFlows in the system.

- 1. Select Administration > WorxFlow from the top menu bar.
- 2. Highlight the WorxFlow and click **Edit**. On the left panel of the Edit screen is the list of categories for the selected WorxFlow.



3. Highlight a **Category** from under the **Selected window** on the left side and click the **Right Arrow** to move the item back to the **Available window** on the right.

4. Click **Close** and any changes made will be automatically saved.

### 3.2.1.7 Creating a New Category from the WorxFlow

The WorxFlow system comes with seven predefined WorxFlows that are comprised of multiple categories. The steps outlined below will assist you with creating a new category for your WorxFlow system.

- 1. Select Administration > WorxFlow from the top menu bar.
- 2. Highlight a WorxFlow and select the Edit button to display the WorxFlow categories.
- 3. Click the New button.
- 4. Type a Category Name in the specified box as shown below.



5. The next step is to move items from the Available windows to the Selected Windows column. Click the **Left** or **Right** arrows to move items back and forth under the columns. You can also change the order of items under the Selected Window, by clicking the **Up** or **Down** buttons.

6. Click Close. Any changes will be made automatically.

## 3.2.1.8 Move the Order of an Item within a Category

The WorxFlow system comes with predefined WorxFlows that are comprised of multiple categories. The steps outlined below will assist you with changing the order of the categories listed for a particular WorxFlow.

1. Select Administration > WorxFlow from the top menu bar.



- 2. Highlight the appropriate Category then click the **Up** or **Down** arrow to move the items.
- 3. Click Close.

### 3.2.1.9 Edit WorxFlow Screen Name

The WorxFlow screen names can be changed on an as needed basis.

1. Select Administration > WorxFlow.

X II	Sequence	Name	
	1	Standard Template	
2050	2	SOAP	
	3	Detailed Template	
New	4	Spinal Exam	
	5	Outcome Assessment	
Ede	6	SOAP Light	
	7	Softwork	
-un	8	Test Workflow	
	9	Dr.G Test	
$\mathbf{\Delta}$	10	Test	
Up	11	Knee Exam	
	12	Example	
own			

- 2. Click on the Screens button.
- 3. Select a screen to change the name of and click the Edit button.



4. Type in a **new screen** name.



- 5. Click Save.
- 6. Select Close, when finished.

#### Note: You must exit ChiroWrite for changes to take effect

Now changes can be seen in the WorxFlow.

e Wayne X	SOAP CH	etom 1		6/20/2012	2 .	66
Subjective Objective Assessment	Exercise Protocol UE	Inferential Test				
Today's Treatments Charges Diagnosis	fran Tana Danaya	Test Change				
SOAP Custom 2 SOAP Custom 3 Quality Measures	Leg Length	De la constante Tenerro de la constante				
Body Picture Cervical Spine Picture Whole Spine Picture						
	Page 1				Cervical Palpation	
	Provacative Testing	ļ		ļ	TEST	
	-				SubTest	
					Ob Test	

## 3.2.2 Billing Codes

Create and edit customized Billing Codes for use in your practice and also add, edit, map and move categories within the Billing Codes.

## 3.2.2.1 Create a New Billing Code

Billing Cod	e					7 🛛
X	Type:	Billing	•			
Close	Code	Alternate Code	Description	Status	Type	
	90040	REX	Re-Exam	Active	Billing	
	90015	NPE	New Patient Exam Detailed History/Ex	Active	Billing	
New	97014	1	Interferential	Active	Billing	
NON	97104	EMS	Electrical Muscle Stimulatiom	Active	Billing	
	99070	CC	Cervical Collar	Active	Billing	1
100	97010		Thermotherapy/Packs	Active	Billing	
Edit	97012		Mechanical Traction	Active	Billing	
	97014		EMS/Interferential	Active	Billing	
-	97018		Paraffin Bath	Active	Billing	1.0
antimate.	97033		Iontophoresis	Active	Billing	
Category	97035		Ultrasound P/C	Active	Billing	
	97124		Deep Muscle Therapy	Active	Billing	
	97140		Manual Therapy Techniques	Active	Billing	
Fee	97530		Therapeutic Exercises - Rehab	Active	Billing	
1-101065	98940		Manipulation/1 to 2 Regions	Active	Billing	
	Anaria		44 - 1 / M. IN -			

- 2. Click New.
- 3. Enter a Code.
- 4. Enter an Alternate Code

Note: The alternate code is used to link to certain external billing systems. If you are linked to an external billing system, generally billing codes will be added there and NOT in ChiroWrite. Eclipse users will edit in ChiroWrite.

5. Enter a **Description**.

🤗 Edit Existin	ng CPT Code		-9- <mark>-</mark> *
	Code:	97104	Z Taxable
Save	Alternate Code:	EMS	
	Description:	Electrical Muscle St	imulatiom
X	Type:	Billing +	
Close	Status:	Active +	

- 6. Click Save.
- 7. Select Close.

## 3.2.2.2 Edit a Billing Code

- 1. Select Administration > Billing Codes.
- 2. Click Edit and make the necessary changes.

n Edit Existin	ng CPT Code		-?
P	Code:	97104	☑ Taxable
Save	Alternate Code:	EMS	
	Description:	Electrical Muscle Stin	nulatiom
X	Туре:	Billing -	
Close	Status:	Active •	

4. Select Close.

Tip: If using an external billing system, generally billing codes will be edited there and NOT in ChiroWrite. Eclipse users will edit in ChiroWrite.

### 3.2.2.3 Add a CPT Category

- 1. Select Administration > Billing Codes.
- 2. Click the **Category** button.
- 3. Click the **New** button and enter the description in the text window.



- 4. Select Save.
- 5. Choose Close.

## 3.2.2.4 Map a Category

- 1. Select Administration > Billing Codes.
- 2. Choose the Category button.
- 3. Click the Mapping button to display the CPT Category window.

🖷 CPT Catego	pories	
	Description	
	Medicare	
Close	Blue Cross	
	Cash	
New		
Edit		
Manning		
mapping		
Up		
Down		

**Types** window on the left side. If you need to move an item back to the right, highlight the item and click the **Right Arrow** to move it back to the right column. You can also put the codes into any order you select by using your **Up** and **Down** arrows on the left side of the window.

Mapping					-9-	
V	Category:	Cash				
Close	Selected Ty	pes		Available Types		
	Code	Description		Code	Description	
	97010 97014	Thermotherapy/Packs EMS/Interferential		90015/NPE 90040/REX	New Patient Exam Detailed Histor Re-Exam	y
	transferral (			97012	Mechanical Traction	
				97014/1	Interferential	
			-	97018	Paraffin Bath	
Up			-	97033	lontophoresis	
				97035	Ultrasound P/C	
own				97104/EMS	Electrical Muscle Stimulatiom	
				97124	Deep Muscle Therapy	
				97140	Manual Therapy Techniques	
				97530	Therapeutic Exercises - Rehab	
				98940	Manipulation/1 to 2 Regions	
				98941	Manipulation/3 to 4 Regions	
				98942	Manipualtion/5 Regions	
				98943	Manipulation/Extremity	
	1 C	THE SECOND SECONDO SECONDO SECOND SECONDO		*		

5. Click Close when finished making changes. Any changes made will be save automatically.

### 3.2.2.5 Edit a Category to a CPT Code

- 1. Select Administration > Billing Codes.
- 2. Highlight the code and click the Category button.

Billing Cod	es					17
X	Type:	Billing	•			
Close	Code	Alternate Code	Description	Status	Type	1
	90040	REX	Re-Exam	Active	Billing	
	90015	NPE	New Patient Exam Detailed History/Ex	Active	Billing	
New	97014	1	Interferential	Active	Billing	
1000	97104	EMS	Electrical Muscle Stimulatiom	Active	Billing	
	99070	CC	Cervical Collar	Active	Billing	1
1000	97010		Thermotherapy/Packs	Active	Billing	
Edit	97012		Mechanical Traction	Active	Billing	
-	97014		EMS/Interferential	Active	Billing	
-	97018		Paraffin Bath	Active	Billing	1.0
21700000	97033		Iontophoresis	Active	Billing	
Category	97035		Ultrasound P/C	Active	Billing	
	97124		Deep Muscle Therapy	Active	Billing	
	97140		Manual Therapy Techniques	Active	Billing	
Fee	97530		Therapeutic Exercises - Rehab	Active	Billing	
1-101063	98940		Manipulation/1 to 2 Regions	Active	Billing	
	Anares		AR 7 1 2 10 10 10 1	1.4.5	.0.=	

- 3. Highlight the Description and click the **Edit** button.
- 4. Enter a new description.
- 5. Select Save.
- 6. Choose Close.

- 1. Select Administration > Billing Codes.
- 2. Highlight a code and click the Category button.
- 3. Click the Up or Down to move the categories to the order that you want them to appear.

🥺 CPT Categ	ories	-2
	Description	
	Medicare	
Close	Blue Cross	
	Cash	
New		
Edit		
Mapping		
Up		
Down		
	L	

4. Click Close.

## 3.2.3 Case Types

The following section will assist you in the steps to create and/or edit a case type within the ChiroWrite program.

### 3.2.3.1 Create a New Case Type

- 1. Select Administration > Case Type.
- 2. Click **New** and type a new description for the Case Type.
- 3. You can also add a custom picture by clicking the Browse button to find the picture and click **Open**.

Note: This option is usually left blank. Please contact technical support at 1-800-642-6082 if you wish to use this feature.

ase Type	-V-
Description:	Test
Custom Picture Path:	\\ANGIESOFFICE-PC\C\$\Users\AngiesOffice\Desktop\My C
	ase Type Description: Custom Picture Path:

- 4. When you are finished, click Save.
- 5. Select Close.

#### 3.2.3.2 Edit a Case Type

- 1. Select Administration > Case Type.
- 2. Highlight the case type and click Edit.
- 3. Enter a new description.
- 4. You can also add a custom picture by clicking the Browse button to find the picture and click Open.

Note: This option is usually left blank. Please contact technical support at 1-800-642-6082 if you wish to use this feature.



- 5. When you are finished, click Save.
- 6. Select Close.

#### 3.2.4 Contacts

The Contacts section allows the user to create contacts within the system. The contacts can be created for any person or organization, but they typically are comprised of Insurance and Referral contacts.

#### 3.2.4.1 Create an Insurance Contact

- 1. Select Administration > Contacts > Insurance.
- 2. Click the New button and enter the contact information for the Insurance company.

Tip: The Name Field is required to add a contact.

🖳 Edit Existin	g Insurance			8
P	Name:	Blue Cross Blue Sh	ield	
Save	Address Line 1:	110 Main Street		
	Address Line 2:	PO Box 3345		
X	City:	Phoenix		
Close	State:	AZ	•	
	ZIP:	90000		
	Phone 1:	(800) 334-3343	Ext.:	
	Phone 2:	(800) 334-3344	Ext.:	
	Fax 1:	(800) 334-1111		
	Fax 2:			

- 3. When you are finished, click Save.
- 4. Select Close.

### 3.2.4.2 Edit an Insurance Contact

- 1. Select Administration > Insurance > Contacts.
- 2. Highlight the Insurance Company and click the **Edit** button.
- 3. Make any necessary changes to the contact information and click Save when you are finished.
- 4. Click Close.

### 3.2.4.3 Create a Referral Contact

- 1. Select Administration > Contacts > Referrals.
- 2. Click the New button and add the necessary Referral information.

#### Tip: The Name Field is required to add a Referral.

🛃 Add New Referrals		
Bave	Title:	Dr. •
	First Name:	Gwain
	Last Name:	Zarbuck
X	Address Line 1:	3342 Springfield Avenue
Close	Address Line 2:	
	City:	Urbana
	State:	IL -
	ZIP:	61802
	Phone 1:	(217) 384-2200 Ext.:
	Phone 2:	() Ext.:
	Fax 1:	<u> </u>
	Fax 2:	(
- 3. When you are finished, click Save.
- 4. Select Close.

#### 3.2.4.4 Edit a Referral Contact

- 1. Select Administration > Contacts > Referrals.
- 2. Choose the contact and click Edit.
- 3. Make the necessary changes.
- 4. When you are finished, click Save.
- 5. Select Close.

#### 3.2.5 Custom Screens

Creating custom buttons in your exam or your soap workflow can help you say additional things in the ChiroWrite notes you produce. They are perfect for adding tests or treatments that you perform in your office that we may not have a specific place in our screens for you to put them. This is also convenient for you to say exactly what you want to say with just the click of a button. This section will show you where to go to create these buttons and how to go about creating them in your system. Learn more about the custom buttons by watching the Custom Buttons Drag and Drop Feature video.

#### 3.2.5.1 Exam Custom

- 1. Administration > Custom Screens > Exam Custom 1, 2 or 3.
- 2. After selecting which Exam Custom screen we are going to place buttons in click Edit.
- 3. You will be presented with a screen with empty buttons or possibly buttons that you have already entered into the system.
- 4. Select an empty button to begin entering information and you will be presented with the screen below.

🚽 Custom Bi	utton Options				2 8
Save	Button Text: Button Color: Print In:	Test XYZ		<u>.</u>	
Close		Allow editing may want to	of the Pl modify t	hrase when selected (Click here if you he selected phrase when used later)	
	Phrase:	Test XYZ was	"result"	positive [*] negative**.	*
Remove					
	Available Varia	hles:			
	First Nam	e	. <	FirstName>	
	First & La	st Name	<	FirstLastName>	
	Title & Las	st Name	<	TitleLastName>	
	His/Her (u	pper case)	<	His/Her>	
	He/She (u	ipper case)	<	He/She>	
	his/her (lo	wer case)	<	his/her>	
	he/she (lo	wer case)	4	he/she>	
	him/her (k	ower case)	<	him/her>	

- 5. Select the **text** for your button to let you know what it is for.
- 6. Select a **color** for your button to show up as.
- 7. Select a section of the exam that you want your button to print in.
- 8. Check the check box if you would like to be able to edit the text when the button is used later.

9. Enter a sentence, phrase or paragraph for what you would like to print out when this button is selected. You can use the variables showed below to assist you as well as using the list and number formats to have the system ask you for additional information.
 10. Select Save, which finished.

11. Click Close.

### 3.2.5.2 SOAP Custom

- 1. Administration > Custom Screens > SOAP Custom, SOAP Custom 2 or 3.
- 2. After selecting which SOAP Custom screen we are going to place buttons in click Edit.
- 3. You will be presented with a screen with empty buttons or possibly buttons that you have already entered into the system.
- 4. Select an empty button to begin entering information and you will be presented with the screen below.



- 5. Select the **text** for your button to let you know what it is for.
- 6. Select a **color** for your button to show up as.
- 7. Select a section of the exam that you want your button to print in.
- 8. Check the check box if you would like to be able to edit the text when the button is used later.

9. Enter a **sentence**, **phrase or paragraph** for what you would like to print out when this button is selected. You can use the variables showed below to assist you as well as using the list and number formats to have the system ask you for additional information.

- 10. Select **Save**, which finished.
- 11. Click Close.

Review the SOAP Custom Video for additional information.

- 1. Administration > Custom Screens > SOAP Custom Light.
- 2. After selecting the SOAP Custom Light screen in click Edit.
- 3. You will be presented with a screen with the buttons already filled out. However, you can make changes to these as needed.

CustomSci	reenEdit - SOAP Custom L	ight			,	-9-
Close	Symptoms Better	Cervical Tenderness	Cervical Trigger Points	Cervical ROM	Subluxations	Subjective Misc.
	Symptoms Same	Thoracic Tenderness	Thoracic Trigger Points	Thoracic ROM	Fixations	Objective Misc.
	Symptoms Worse	Lumbar Tenderness	Lumbar Trigger Points	Lumber ROM	Other	Assessment Misc.
	Wellness No Aggravation	Sacral Tenderness	Sacral Trigger Points	Sacral ROM	Assessment Better	Plan Misc.
	Wellness With Aggravation	Cervical Hypertonicity	Cervical Swelling	Cervical WNL	Assessment Same	
	Sleeping	Thoracic Hypertonicity	Thoracic Swelling	Thoracic WNL	Assessment Worse	
	Feeing	Lumbar Hypertonicity	Lumbar Swelling	Lumbar WNL	Plan - No Change	
	DLA	Sacral Hypertonicity	Sacral Swelling	Sacral WNL	Plan - Change	

4. Select a button to begin entering or editing information and you will be presented with the screen below.



- 5. Select the **text** for your button to let you know what it is for.
- 6. Select a **color** for your button to show up as.
- 7. Select a section of the exam that you want your button to print in.
- 8. Check the check box if you would like to be able to edit the text when the button is used later.

9. Enter a sentence, phrase or paragraph for what you would like to print out when this button is selected. You can use the variables showed below to assist you as well as using the list and number formats to have the system ask you for additional information.
 10. Select Save, which finished.

11. Click Close.

More information can be found by watching the SOAP Custom Light Video.

## 3.2.6 Disciplines

The Discipline function allows you to create and edit the Disciplines and Disciplines Areas, as well as, the Discipline Area Options. The Configuration types can also be created and edited in this option.

## 3.2.6.1 Create a Discipline

1. Select Administration > Disciplines.

e Disciplines	
X	Discipline Chiropractic
Close	
Edit	
Areas	
Config Types	

- 2. Select New and enter the Discipline description.
- 3. Click the Browse button to search for the image and select Open.
- 4. When you are finished, click Save.
- 5. Select Close.

### 3.2.6.2 Edit a Discipline

- 1. Select Administration > Disciplines.
- 2. Highlight the Discipline and click Edit to make the necessary changes.
- 3. When finished, click **Save**.
- 4. Select Close.

### 3.2.6.3 Create a New Discipline Area

- 1. Select Administration > Disciplines.
- 2. Highlight the Discipline and click the Areas button.
- 3. The Discipline Areas window will appear. Click New.
- 4. Enter an Area/Description.
- 5. Enter a Tooltip.
- 6. Select the Status as either Active or Inactive.



Tip: The Area/Description field is the minimum requirement for a discipline to be created. Please do not make any changes to the coordinates area. If you make changes it will cause critical system malfunctions.

- 7. Click Save.
- 8. Select Close.

## 3.2.6.4 Edit a Discipline Area

- 1. Select Administration > Disciplines.
- 2. Highlight the Discipline and click the Areas button and the window below will appear.
- 3. The Discipline Areas window will appear. Highlight the area and click the Edit button.



Warning: Please do not make any changes to the coordinates area. If you make changes it will cause critical system malfunctions.

- 4. Edit the Area/Description.
- 5. Edit the Tooltip.
- 6. Change the Status.



- 7. Click Save.
- 8. Select Close.

## 3.2.6.5 Create a Discipline Area Option

- 1. Select Administration > Disciplines.
- 2. Highlight the Discipline and click Areas.
- 3. Select an area and click Area Options.
- 4. Click New to add a new area option.
- 5. Select an Option Type. The system has the following predefined options:
- Pallative
- Provocative
- Quality
- Radiating
- Timing
- Side Effects
- Specifics

#### 6. Specify an **Option name**.

🖳 Add New	Area Option		2 🔀
	Discipline:	Chiropractic	
Save	Area:	Diarrhea	
	Option Type:		
X	Option Name:		
Close			

- 7. Click Save.
- 8. Select Close.

### 3.2.6.6 Edit a Discipline Area Option

- 1. Select Administration > Disciplines.
- 2. Highlight the Discipline and click Areas.
- 3. Select an area and click Area Options.
- 4. Click Edit to make changes to an existing new area option.

💀 Edit Existi	ng Area Option	- P - 💌	
	Discipline:	Chiropractic	
	Area:	Abdomen	
Save	Option Type:	Pallative	
X	Option Name:	Pallative	
Close			

- 7. Click Save.
- 8. Select Close.

## 3.2.6.7 Create the Discipline Area Option Types

- 1. Select Administration > Disciplines.
- 2. Highlight the Discipline and click Areas.
- 3. Select an area and click Area Options.
- 4. Click Option Types.

5. In order to move items from the **Available Types** to the **Selected Types**, highlight the item in the right window and click the **Left** or **Right** arrows to move the items back and forth. If you want to change the order of the **Selected Types**, highlight the item in the left column and click the **Up** or **Down** arrows to arrange the items.

🚽 Options Ty	pes				8 💌
	Discipline: Chiropractic				
	Area:	Abdomen			
Ciose	Option:	Side Effects		•	
	Selected Ty	pes (Limit 20 items)		Available Types	
	Sequence	Туре		Туре	*
	1 1 2 1 3 0 4 1	Bloating		Burning	
		Bruising		Buzzing in Ears	
		Constipation	-	Clicking	
Up		Diarrhea	<b>(</b>	Decreased ROM	
	5	Nausea		Deep Breathing	
Down	6	Paresthesia		Dizziness	
	7	Rigidity		Grinding	
	8	Skin Changes		Increased Sensitivity	
	9	Vomiting		Inflammation	
				Locking	
				Loss of Balance	
				Numbness	
				Other	•

6. Select Close. Any changes you make will be automatically saved.

# 3.2.6.8 Create a Config Type

- 1. Select Administration > Disciplines.
- 2. Highlight the Discipline you want to configure and click Config Types.
- 3. Click the New button and the following window will appear.

🛃 Add New Option Type	? <b>X</b>
Option:         •           Save         Description:	
Print 1:	
Print 2:	
Close Print 3:	

- 4. Select an option from the predefined list which includes the following:
- Pallative
- Provocative
- Quality
- Radiating
- Timing
- Side Effects
- Specifics
- 5. Enter a description.
- 6. Enter the appropriate description in the Print 1, 2, and/or 3 boxes.
- 7. Select Save.
- 8. Click Close.

## 3.2.6.9 Edit a Config Type

- 1. Select Administration > Disciplines.
- 2. Highlight the Discipline you want to configure and click Config Types.
- 3. Highlight the item and click the **Edit** button and a window similar to the one shown below will appear.

🛃 ImageOptic	onTypes		7 🔜
X	Туре	Description	A
Close	Pallative	Chiropractic tx	=
	Pallative	Heat	
	Pallative	lce	
New	Pallative	Knees to Chest	
	Pallative	Laying on left side	
	Pallative	Laying on right side	
Edit	Pallative	Leaning Left	
	Pallative	Leaning Right	
	Pallative	Lying Down	
	Pallative	Medication	
	Pallative	Nothing	
	Pallative	Range Of Motion	
	Pallative	Resting	
Copy To	Pallative	Sitting	
	Pallative	Standing	
	Pallative	Stretching	
	Pallative	test	
	Provocative	Bending	
	Provocative	Bowel Movements	
	Provocative	Bright Lights	
	Provocative	Chewing	-

- 4. Make the necessary changes and click **Save**.
- 5. Select Close.

- 1. Select Administration > Disciplines.
- 2. Highlight the Discipline you want to configure and click Config Types.
- 3. Select the Copy To button and the discipline areas window appears.
- 4. Highlight the discipline area and click the **Copy** button.
- 5. Click Close.

## 3.2.7 Diagnostic Codes

Create and edit customized Diagnostic Codes for use in your practice and also add, edit, map and move categories within the Diagnostic Codes.

## 3.2.7.1 Create New Diagnostic Codes

#### 1. Select Administration > Diagnostic Codes.

🥵 Diagnostic	Codes		-2-
	Code	Description	*
	300	Anxiety	
Close	307.81	Tension Headache	
hanness and have been started	310.2	Post Concussion Syndrom	
	337.9	Arm Neuropathy	
New	345	Median nerve compression	
and search and	346	Migraine	
	346.9	Migraine	
Edit	348.9	Cephalgia Migraine NOS Unspecified	
Eun	351	Bell's Palsy	
	353.8	Intercostal Neuritis	
<u> </u>	354	Carpal Tunnel Syndrome	
Category	354.0	Carpal Tunnel Syndrome	
	354.9	Elbow Neuritis/Neuralgia L R B	
	255 7	Hin Neuritis/Neuralnia	

#### 2. Click New.

🖳 Add New	Diagnostic Code		- ?- <b>- ×</b> -
Save	Code: Description: Status:	Active -	
Close			

- 3. Enter a Code.
- 4. Enter a **Description**.

- 5. Click Save.
- 6. Select Close.

## 3.2.7.2 Edit Diagnostic Codes

- 1. Select Administration > Diagnostic Codes.
- 2. Click Edit.

🖳 Edit Existin	ng Diagnostic Code			?
Р	Code:	307.81		
Save	Description:	Tension He	adache	
	Status:	Active	•	
Close				

- 3. Change a Code or Description or you can choose to make the option Inactive.
- 4. Click **Save**, when finished.
- 5. Select Close.

## 3.2.7.3 Add a Category for Diagnostic Codes

- 1. Select Administration > Diagnostic Codes.
- 2. Click the Category button.
- 3. Click the New button and enter the description in the text window.

🖳 Add New	Diagnosis Category	8 💌
Save	Description:	
Close		

- 4. Select Save.
- 5. Choose Close.

## 3.2.7.4 Put Diagnostic Codes in Categories

- 1. Select Administration > Diagnostic Codes.
- 2. Choose the Category button.
- 3. Click the **Mapping** button to display the Diagnostic Category window.

4. Select a code to highlight under the **Available Types** window to the right. Click the **Left Arrow** to move the item to the **Selected Types** window on the left side. If you need to move an item back to the right, highlight the item and click the **Right Arrow** to move it back to the right column. You can also put the codes into any order you select by using your **Up** and **Down** arrows on the left side of the window.

	Category	Cervical				
Close	Selected	Types		Available	Types	
	Code	Description		Code	Description	
	739.1	Cervical Region C1 to C7		720.2	Sacroilms	
	346.9	Migraine		721.3	Lumbar Lumbar Spondylosis (DSD)	
	722.2	Cervical Disc. Herniation		721.6	D.I.S.H. Disease	1
	722.4	Cervical Disc. Degeneration Thinning		722	Re-injury of herniated Disc	1
	722.9	Cervical Disc Syndrome	-	722.1	Lumbar Disc Bulging	
Up	723.2	Cervicocranial Syndrome		722.3	Schmorls Sprain/Strain	
	737.1	Cervical Kyphosis/Hypolordosis	-	722.52	Lumbar Disc Degeneration	
Down				722.6	Degeneration of intervertebral disc	
			-	722.7	Intervertebral Disc Disorder with Myelpa	
				722.90	Unspecified region/disc disorder	
				723.1	Cervicalgia	
				723.3	Cervico-Brachial Syndrome	
				723.4	Brachial Neuritis	
				723.5	Torticollis Unspecified	
				724.1	Pain-thoracic spine	
		.m.,	1			

5. Click Close when finished making changes. Any changes made will be save automatically.

### 3.2.8 Dynamic Options

Dynamic options are additional comments that can be associated with certain orthopedic tests. This section allows the user to enter in comments that can be used for any patient and makes selection from a drop down box easy for the user. Sentences can be entered in two different ways as shown below. Learn more about creating dynamic options by watching the <u>Dynamic Notes for</u> Orthopedic Test Sections video.

#### Administration

1. Select Administration > Dynamic Options.

P Dynamic O	ptions				7
	Screen:	Ortho Cervical Test	_	-	
Close	Option	Lumbar Tests Neuro Cranial Nerves			Sequence
	Carotid M	Ortho Cervical Test		s and tingling in their right hand.	1
	Cervical	Ortho Thoracic Outlet Tests			
New	Foramina	Sacrollac Test			
	Foramina	al Comp Left			
	Foramina	al Comp Right			
5.0	George's	Test			
CUIL	Jackson	's Comp Both			
	Jackson	's Comp Left			
	Jackson	's Comp Right			
Remove	Kines				
	Lhermitte	r?s Sign			
	O?Dono	ghue?s Left			
	O?Dono	ghue?s Right			
Up	Shoulder	Depression Both			
	Shoulder	Depression Left			
Down	Shoulder	Depression Right			
	Soto Hal	I	*		

2. Sentences can then be entered for each test by **selecting a screen** from the top, then **selecting a specific test** and clicking the **New** button to enter in a new sentence to be used for that specific test. It's a good idea to have the sentence be as complete as possible because it will be printing with other sentences in the report.

#### Entering on the Fly

Bruce Maple ×						 -	
tandard Template •	Ortho Cervical	Test		73/4	5/10/2012	 	
Pain Intensity -	Page 1 Page 3		- Andrews	the second second			
Examination	O'Donoghue's Left	© Negative	© Positive				
Mensuration Circumfe	O'Donoghue's Right	O Negative	© Positive				
Posture Station Obse ROM Cervical ROM Dorsal	George's Test.	© Negative ⊡History	© Positive	E High BP			
ROM Lumbar ROM Spoulder	Carotid Murmurs	O Negative	C Positive				
ROM Elbow E ROM Knee ROM Wrist	Kines.	O Negative	© Positive		•		
ROM Hp ROM AnselF oot	Distraction	O No Change	© Increase	O Decrease O Rele	e		
Neuro Referes	Cervical Compression:	© Negative	© Positive				
Neuro Dermatome	Foraminal Comp Left.	© Negative	© Positive				
Ortho Head and TMJ	Foraminal Comp Right	O Negative	© Positive	and brighing in their	sale hand		
Ortho Thorack Outlet	Foraminal Comp Both	© Negative	© Positive	Patient left matchings	s and trigting		
Ortho Thorack Spine	Jackson's Comp Left	© Negative	C Positive				
Sacrollac Test	Jackson's Comp Right	© Negative	© Positive		-		
Ortho Elbow Tests	Jackson's Comp Both:	© Negative	C Positive				
- Ortho Winst Tests Knee Tests	Livermitte's Sign	O Negative	© Positive				
Foot Tests UE Muscle Testing LE Muscle Testing	Valsalva's ;	Negative	© Positive	Pain At	-		1

When on certain orthopedic test screens, you can use the drop down to find the sentence you are looking to add to your patient's note or you can type whatever you would like to say in the box. ChiroWrite will save that sentence so that you are able to utilize it for other patient's.

## 3.2.9 Education

#### 1. Select Administration > Education.

The Patient Education section allows you to create links to specific reading material that might be useful to certain patients. It also lets you link to certain reading material that you may already have on your computer. Learn more about using the patient education

section by watching the Patient Education video.

ee Education		-?
	Description	Status
X	Anxiety Attacks	Active
Close	Asthma	Active
	Avandia	Active
	Azmacort	Active
New	Bells Palsey	Active
	Carpal Tunnel	Active
	Cholesterol	Active
Edit	Diabeta (Glyburide)	Active
Euit	Diabetes Mellitus Treatment	Active
	Fasting Blood Glucose	Active
	Migraine Headache	Active
Loursh	Photophobia	Active
Launch		

Clicking the **New button** will allow you to create a new education resource and clicking **Edit** will allow you to make changes to and existing resource. Clicking the **Launch** button after selecting a resource will launch the resource you can take a look at it.

Resources can be setup by clicking the **New** button. A description of the resource will tell you what it is used for as well as the link or path to where it is found. This can either be a website, online pdf or another document located on a computer in your office in a shared folder. Key words is used in finding the document by ChiroWrite. A status of inactive will make the resource no longer usable by the system. Think of it as discontinuing a resource.

🤗 Edit Existing Education Resou		ce	and the second	-172	7
P	Description:	Diabeta (Glyburide)			
Save	Link/Path:	http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000833/			<b>1</b>
	i	Example: 724.2 low back tylenol			
X	Key Words:	Diabeta Glyburide			^
Close					*
	Status:	Active			

Actually using the resource is rather simple navigate to **Patient Activities > Education** and make your selections as needed. Clicking **New** will allow you to access the resources you may have already setup in the system, **Launch** will allow you to re-access anything you may have already run and **Medline Plus Connect** will allow you to access any resources for conditions the patient may have that you may not have previously setup in the system.

🛃 Education		- 7 <b>- X</b> -
	Description	Date Given
	Diabeta (Glyburide)	7/26/2011
Close	Medline Plus ICD: 250.02 - Diabetes Mellitus, Type 2	7/26/2011
New		
Launch		
Medline Plus Connect Remove		

## 3.2.10 Employees

ChiroWrite gives you the ability to add employee accounts to allow employees to login and make changes to patient files. This is also necessary if you want the ability to send instant messages using the ChiroWrite system.

## 3.2.10.1 Create New Employee Login

- 1. Select Administration > Employees.
- 2. Click New to enter a new employee.

Employee	s Edit	-2-1
	Employee Id:	1
	First Name:	Softworx
Save	Last Name:	Solutions
X	User Name:	Softworx
Close	Password:	
	Verify Password:	•••••
	Security Level:	Administrator
	Expires:	
		I Listen For Alerts
		Closed
	Emergency Security:	
	Provider:	Solutions, DC, Softworx

3. Enter employee information and password. Security level and expiration date can be left blank as well as closed. Selecting closed will disable the employee account making it no longer usable.

Note: If you are using logins to be able to send instant messages please check the listen for alerts box.

- 4. Select Save.
- 5. Click Close.

## 3.2.10.2 Edit Employee Login

- 1. Select Administration > Employees.
- 2. Highlight the employee login you wish to change and select Edit.

Employee	s Edit		7
	Employee Id:	1	
Carro	First Name:	Softworx	
Save	Last Name:	Solutions	
Х	User Name:	Softworx	
Close	Password:	•••••	
	Verify Password:		
	Security Level:	Administrator	•
	Expires:		
		Ilisten For Alerts	
		Closed	
	Emergency Security:		•
	Provider:	Solutions, DC, Softworx	

- 3. Enter any necessary changes. This is where an employee login can be disabled by clicking the check box next to closed.
- 4. Select Save.
- 5. Click Close.

## 3.2.11 Image Type

Image Type allows you to create and edit image types that will be use when adding images or scans to a patient file. Using this, you can determine at a glance, what image or scan you are working with at any time.

# 3.2.11.1 Create New Image Type

1. Select Administration > Image Types.

🖳 Image Typ	es	- ? <b>- ×</b> -
	Image Type	Copy Local
	Mock Up	No
Close	Patient Intake Forms	No
	Patient Picture	No
	X-Rays	No
New		
Edit		

2. Click **New** to enter a new image type.

😔 Add New I	mage Type	
B	Description: Scan File Type:	
Close		Leave blank to create PDF file (ChiroWrite Default) JPG - use for single image only, no multi page TIFF - only use if directed to and having problem with PDF files

3. Enter in a **Description**.

4. Choose a **Scan File Type**, if needed. If you want images to open using the Windows default image program you can check Open using Microsoft Windows system default program. Learn more about this by watching <u>Images Should Open using Windows Default</u> <u>Program</u> video.

- 5. Select Save.
- 6. Click Close.

## 3.2.11.2 Edit Image Type

- 1. Select Administration > Image Types.
- 2. Click Edit to edit an image type.

😔 Add New I	mage Type	· · · · · · · · · · · · · · · · · · ·
Bave	Description: Scan File Type:	
Close		Leave blank to create PDF file (ChiroWrite Default) JPG - use for single image only, no multi page TIFF - only use if directed to and having problem with PDF files Open using Microsoft Windows system default program

3. Change the **Description**, if needed.

4. Choose a **Scan File Type**, if needed. If you want images to open using the Windows default image program you can check Open using Microsoft Windows system default program. Learn more about this by watching <u>Images Should Open using Windows Default</u> Program video.

- 5. Select Save.
- 6. Click Close.

### 3.2.12 Narratives

Creating customized phrases and sentences is one of the most popular functions of the software. The Introduction Phrases, Phrase Types and Ending Phrases can be created or edited for the reports system. The system also provides the ability to create and edit Prognosis Phrases and types for your patients reports.

#### 1. Select Administration > Narratives > Introduction Phrases.

2. Highlight the phrase and click the Edit button.

	Type:	Personal Injury - Au	tos		
	(1)	Button Text	Phrase:		
Save	Phrase 1:	MVA Mid	<titlelastname> initially presented to this office on <visitdate> for consultation, examination and</visitdate></titlelastname>		ĵ.
Close	Phrase 2:	MVA Mod <titlelas< td=""><td colspan="2">tName&gt; reported that <he she=""> was in a motor vehicle accident on</he></td></titlelas<>		tName> reported that <he she=""> was in a motor vehicle accident on</he>	
	Phrase 3:				^
	Phrase 4:				*
	Phrase 5:				*
		Available Variables First Name First & Last Na Title & Last Na His/Her (upper He/She (upper his/her (lower of he/she (lower of Visit Date	me case) case) :ase) :ase)	< <u>FirstName&gt;</u> < <u>FirstLastName&gt;</u> < <u>TriteLastName&gt;</u> < <u>His/Her&gt;</u>	

3. The system allows the creation of up to five Phrases per Introduction. Each Phrase that is listed has an area called **Button Text.** Enter the name that you want to appear on the button in the system.

4. The next step is to edit or create additional phrases for this topic. Type the phrase and use the **Available Variables** shown at the bottom of the window to have the system automatically fill in the clients name, visit date, accident date, etc. As you type your phrase you can click on the blue link next to the available variable you would like to use and it will be automatically entered into the phrase.

#### Tip: Phrases must be typed in complete sentences.

- 5. When you are finished click **Save**.
- 6. Select Close.

### 3.2.12.2 Create a New Introduction Phrase Type

- 1. Select Administration > Narratives > Introduction Phrases.
- 2. Click the Types button.
- 3. Select New at the Introduction Types window.

New Add New	Introduction Type	
E Save	Description:	
Close		

- 4. Enter a description and click **Save** when you are finished.
- 5. Select Close.

## 3.2.12.3 Edit an Introduction Phrase Type

- 1. Select Administration > Narratives > Introduction Phrases.
- 2. Click the Types button.
- 3. Highlight the Introduction Phrase Type and click Edit.

100511	CONTRACTOR AND	And the second s	
	Description:	Workers Comp.	
Save	12		
	-		

- 4. Click Save.
- 5. Select Close.

## 3.2.12.4 Edit a Prognosis Phrase

- 1. Choose Administration > Narratives > Prognosis Phrases.
- 2. Highlight the Prognosis and click Edit.



3. The system allows the creation of up to five Phrases per Introduction. Each Phrase has an area called **Button Text** to enter the name that you want to appear on the button in the system.

4. The next step is to edit or create additional phrases for this topic. Type the phrase and use the **Available Variables** shown at the bottom of the window to have the system automatically fill in the clients name, him/her, etc. As you type the phrase, you can click on the blue links next to the variable and it will display in your phrase and automatically fill in the client information when you run reports.

#### Tip: Phrases should be typed in complete sentences.

5. When you are finished, click Save.6. Select Close.

### 3.2.12.5 Create a Prognosis Phrase Type

- 1. Choose Administration > Narratives > Prognosis Phrases.
- 2. Select the Types button.
- 3. Click the **New** button and enter a description.

Add New	Prognosis Type	-2-
Bave	Description:	
Close		

- 4. Click Save.
- 5. Select Close.

#### 3.2.12.6 Edit a Prognosis Phrase Type

- 1. Choose Administration > Narratives > Prognosis Phrases.
- 2. Select the Types button.

💀 Prognosis I	Phrases 2	×
	Prognosis Types	
	Excellent	
Close	Fair	
	Favorable	
	Good	
Edit	Guarded	
	Poor	
Types		

- 3. Select the prognosis type you wish to change and click the Edit button.
- 4. Make the necessary changes and click the Save button.
- 5. Select Close.

#### 3.2.12.7 Edit an Ending Phrase

#### 1. Select Administration > Narratives > Ending Phrases.

2. Highlight the phrase and click the Edit button.

🛃 Ending P	Thrases Edit				-0-0-0
100	Type:	Standard			
		Button Text:	Phrase:		
Save	Phrase 1:	Sample 1	In conclus	ion, it can be seen that	*
					-
~	Phrase 2.	Sample 2	Based on	the findings noted	1. C
Close	1				-
	Phrase 3:				·
	Phrase 4:				
	Phrase 5:				
					÷.
		Available Variable	es:		
		First Name		<firstname></firstname>	
		First & Last	Name	<firstlastname></firstlastname>	
		Title & Last	Name	<titlelastname></titlelastname>	
		His/Her (up)	per case)	< <u>HisHer&gt;</u>	
		He/She (upp	per case)	<he she=""></he>	
		his/her (low	er case)	shis/here	
		he/she (low	er case)	<he sho=""></he>	
		him/her (low	ver case)	<u>shimher&gt;</u>	
		Visit Date		< <u>VisirDate&gt;</u>	
		Accident Da	de .	<accidentdate></accidentdate>	

3. The system allows the creation of up to five Phrases per Introduction. Each Phrase that is listed has an area called **Button Text**. Enter the name that you want to appear on the button in the system.

4. The next step is to edit or create additional phrases for this topic. Type the phrase and use the **Available Variables** shown at the bottom of the window to have the system automatically fill in the clients name, visit date, accident date, etc. As you type your phrase you can click on the blue link next to the available variable you would like to use and it will be automatically entered into the phrase.

#### Tip: Phrases must be typed in complete sentences.

- 5. When you are finished click Save.
- 6. Select Close.

### 3.2.12.8 Create an Ending Phrase Type

- 1. Select Administration > Narratives > Ending Phrases.
- 2. Click the **Types** button.
- 3. Select New at the Ending Types window.

New Ending	Type	
De Save	scription:	

- 4. Enter a description and click Save when you are finished.
- 5. Select Close.

## 3.2.12.9 Edit an Ending Phrase Type

- 1. Select Administration > Narratives > Ending Phrases.
- 2. Click the **Types** button.
- 3. Highlight the Ending Phrase Type and click Edit.

Description: Standard	Edit Existi	ng Ending Type		
Save	Н	Description:	Standard	
	Save			

- 4. Click Save.
- 5. Select Close.

## 3.2.13 Note Types

Note Type allows you to create and edit note types that will be use when adding miscellaneous notes to a patient file. Using this, you can add notes not connected to any particular visit that will not print in your notes; so that you can track things like missed appointments.

## 3.2.13.1 Create New Note Type

1. Select Administration > Note Types.

🖳 Note Types		? <mark></mark>
	Note Type	Status
	Missed Appointment	Active
Close	Standard	Active
	Visit Notes	Active
New		
Edit		

2. Click **New** to enter a new note type.

Add New	Note Type	
Bave	Description: Status:	
Close		

- 3. Enter in a **Description**.
- 4. Choose a Status of active.
- 5. Select Save.
- 6. Click Close.

# 3.2.13.2 Edit Note Type

- 1. Select Administration > Note Types.
- 2. Click **Edit** to change a note type.

🥶 Edit Existi	ng Note Type		7
P	Description:	Missed Appointment	
Save	Status:	Active	
Save	Status:	Active	
Close			

- 3. Change the **Description**, if needed.
- 4. Choose a Status of active or inactive.
- 5. Select Save.
- 6. Click Close.

## 3.2.14 Offices

The Office function is helpful for companies that have multiple locations and/or satellite offices. You can create an office entry for each location so that the patients can be assigned to a specific location and the company can better track the caseload at each location.

### 3.2.14.1 Create Office

- 1. Select Administration > Offices.
- 2. Click **New** and enter the relevant office information.

#### Tip: Office name, Address, City and State are required fields to create an office location.

🛃 Edit Existin	g Office	2-	
<b>P</b>	Name:	Uptown Wellness Center	1
Save	Address Line 1:	123 Main Street	
	Address Line 2:		
X	City:	Chicago	
Close	State:	<b>I</b> L •	
	ZIP:	60950	
	Phone 1:	60950	
	Phone 2:	() <u></u>	
	Fax 1:	() <u></u>	
	Fax 2:	()	

- 3. Click Save.
- 4. Select Close.

### 3.2.14.2 Edit Office

- 1. Select Administration > Offices.
- 2. Select the office you want to make changes to and click Edit.
- 3. Make the necessary changes and click Save.
- 4. Select Close.

#### 3.2.15 Outcome Assessments

In this section, you will find the ability to make changes to four questionnaires that ChiroWrite provides. These questionnaires include the Daily Living Assessment, which is the ChiroWrite standard, Roland Morris, Oswestry Low Back Index and Neck Disability Index. Questions can be hidden or the wording edited depending on the questionnaire you are working with.

## 3.2.15.1 Daily Living Assessment - ChiroWrite

The Daily Living Assessment Administration function allows you to customize the questionnaire options for the patient when assessing their functionality and pain.

#### 3.2.15.1.1 Edit a Daily Living Assessment Area

- 1. Select Administration > Outcome Assessment > Daily Living Assessment ChiroWrite Standard.
- 2. Highlight the assessment area and click Edit.



3. Edit or type the sentences that you would like to appear.

#### Tip: Options must be typed in complete sentences.

- 4. Click the Save button.
- 5. Select Close.

The Roland Morris Questionnaire assessment options can be customized to assess the patient's functionality and pain.

## 3.2.15.2.1 Edit a Roland Morris Questionnaire

1. Select Administration > Outcome Assessment > Roland Morris Questionnaire. There are two pages of assessment screens as shown below:

rris Edit		7 💌
Page	Page 2	
1.	I stay at home most of the time because of my back.	
2.	I change position frequently to try to get my back comfortable.	
3.	I walk more slowly than usual because of my back.	
4.	Because of my back, I am not doing any jobs that I usually do around the house	e.
5.	Because of my back, I use a handrail to get upstairs.	
6.	Because of my back, I lie down to rest more often.	
7.	Because of my back, I have to hold on to something to get out of an easy chair	
8.	Because of my back, I try to get other people to do things for me.	
9.	I get dressed more slowly than usual because of my back.	
10.	I only stand up for short periods of time because of my back.	
11.	Because of my back, I try not to bend or kneel down.	
12.	I find it difficult to get out of a chair because of my back.	
	res Edit Pages 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.	Institution       Page 2         1       I stay at home most of the time because of my back.         2.       I change position frequently to try to get my back comfortable.         3.       I walk more slowly than usual because of my back.         4.       Because of my back, I am not doing any jobs that I usually do around the house         5.       Because of my back, I use a handrail to get upstairs.         6.       Because of my back, I lie down to rest more often.         7.       Because of my back, I have to hold on to something to get out of an easy chair         8.       Because of my back, I try to get other people to do things for me.         9.       I get dressed more slowly than usual because of my back.         10.       I only stand up for short periods of time because of my back.         11.       Because of my back, I try not to bend or kneel down.         12.       I find it difficult to get out of a chair because of my back.

🖶 Roland M	orris Edit	
	Page	1 Page 2
Save	13.	My back is painful almost all of the time.
	14.	I find it difficult to turn over in bed because of my back.
Close	15.	My appelite is not very good because of my back.
	16.	I have trouble putting on my socks (or stockings) because of the pain in my back.
	17.	I can only walk short distances because of my back pain.
	18.	I sleep less well because of my back.
	19.	Because of my back pain, I get dressed with the help of someone else.
	20.	I sit down for most of the day because of my back.
	21.	I avoid heavy jobs around the house because of my back.
	22.	Because of back pain, I am more initable and bad tempered with people than usual.
	23.	Because of my back, I go upstairs more slowly than usual.
	24.	I stay in bed most of the time because of my back.

2. Edit or type the sentences for the questionnaire.

Tip: Options must be typed in complete sentences.

3. Click the **Save** button.

4. Select Close.

#### 3.2.15.3 Oswestry Low Back Index

The Oswestry Low Back Index Assessment options can be customized to assess the patient's functionality and pain.

## 3.2.15.3.1 Edit an Oswestry Low Back Index

1. Select Administration > Outcome Assessment > Oswestry Low Back Index. There are several sections that can be editing as shown in the screen below.



- 2. Highlight the area you would like to change and click edit.
- 3. Make any changes and click save.
- 4. Click close for that window and you will be brought back to the screen above.
- 5. Select additional areas as needed, when finished, click close.

### 3.2.15.4 Neck Disability Index

The Neck Disability Index Assessment options can be customized to assess the patient's functionality and pain.

#### 3.2.15.4.1 Edit a Neck Disability Index

1. Select Administration > Outcome Assessment > Neck Disability Index. There are several sections that can be editing as shown in the screen below.

Neck Disal	ulity Assessment	-9-
	Daily Living Assessment Area	
X	Concentration	
Close	Driving	
_	Headache	
5.0	Lifting	
Eat	Pain Intensity	
	Personal Care	
	Reading	
	Recreation	
	Sleeping	
	Work	

- 2. Highlight the area you would like to change and click edit.
- 3. Make any changes and click **save**.
- 4. Click close for that window and you will be brought back to the screen above.
- 5. Select additional areas as needed, when finished, click close.

## 3.2.16 Providers

If you have more than one doctor at your location, branch or satellite office you can add the providers through this function. This will assist the doctors in keeping track of which patients are being treated by them. Doctors can even add their signature to their file so ChiroWrite will generate their electronic signature with the note. Review the <u>Provider Signature Video</u> to see how.

## 3.2.16.1 Create a New Provider

1. Select Administration > Provider.

Providers	
Close	Provider Names Brownie, DC, Charles House, DC, Greg Polo, D.C, D.O, Marco
New	Rosenburg, DC, Eliane Solutions, DC, Softworx
Edit	

2. Click the New button and enter the provider information.

First Name:	Softwork			
Last Name:	Solutions, DC			
Phone 1:	(_) Ph	one 2 ( ) -		
Fax:				
License No:	999994949994	Tax/EIN:	taxd34593485	
UPIN	upin484	NPt:	NPI3485490	
Misc:			•	
Signature File:			*	
Signature	-			
organization.	Samors	Sult	5	Signature
ogniov.	Use the tag <signeddate Signature Text the note used unless there is an a</signeddate 	e> below if you wisk was considered sig actual signed date fi	h to include the dat ned. The visit date or the note.	Signature signature te in the
Signature Text	Use the tag <signeddate Signature Text the note used unless there is an a Electronically Signed <s< td=""><td>e&gt; below if you wish was considered sig actual signed date if ignedDate&gt;</td><td>h to include the dat ned. The visit date or the note.</td><td>Signature Signature te in the s will be</td></s<></signeddate 	e> below if you wish was considered sig actual signed date if ignedDate>	h to include the dat ned. The visit date or the note.	Signature Signature te in the s will be
Signature Text Print Header	Use the tag <signeddak Signature Text the note tured unless there is an a Electronically Signed <s Provider:</s </signeddak 	South and the second	h to include the dat ned. The visit date or the note (Example - Pro	te in the will be
Signature Text Print Header	Use the tag <signeddaw Signature Text the note used unless there is an i Dectronically Signed <s Provider: Waiver Signed?</s </signeddaw 	Subt K e> below if you wisk was considered sig actual signed date fi ignedDate>	h to include the dat ned. The visit date or the note. (Example - Pro	Signature signature is will be wider.)
Signature Text Print Header External Id	Use the tag <signeddate Signature Text the note used unless there is an it Electronically Signed <s Provider: Waiver Signed? (Used by exc</s </signeddate 	e> below if you wisk was considered sig actual signed date fi ignedDate> ternal interfaces)	h to include the dat ned. The visit date or the note. (Example - Pro	Signature signature will be

- Tip: The First and Last Name fields are required to add a provider.
- 3. Click the **Save** button.
- 4. Select Close.

# 3.2.16.2 Edit a Provider

#### 1. Select Administration > Provider.



2. Highlight the Provider, click Edit, and make the necessary changes.

	ng Flovider			L.K.C
10	First Name:	Softwork		
Save	Last Name:	Solutions, DC		
-	Phone 1:	() Phone	2	
х	Fax:	<u> </u>		
Close	License No:	999994949994	Tax/EIN:	taxd34593485
	UPIN	upin484	NPt	NPI3485490
	Misc:			•
				-
	Signature File:			
	Signature File Signature	Selmors <	Sector	Clear Signature
	Signature File Signature	Support Support	below if you wis is considered sig al signed date f	Clear Signature h to include the date in the red. The visit date will be or the note.
	Signature File Signature Signature Text	Set the tag <signeddate> Signature Text the note was used unless there is an act Electronically Signed <signed< td=""><td>below if you wis considered sig al signed date if edDate&gt;</td><td>h to include the date in the ned. The visit date will be or the note.</td></signed<></signeddate>	below if you wis considered sig al signed date if edDate>	h to include the date in the ned. The visit date will be or the note.
	Signature File Signature Signature Text Print Header	Support the tag <signetdate> Signeture Text the note was used unless there is an act. Electronically Signet <signe Provider:</signe </signetdate>	below if you wis considered sig al signed date if cdDate>	Clear Signature h to include the date in the ned. The visit date will be or the note. (Example - Provider.)
	Signature File Signature Signature Text Print Header	Saffward Signet/Dates Signature Text the note was used unless there is an act Electronically Signed <signe Provider: Warver Signed?</signe 	below if you wis considered sig al signed date f rdDate>	h to include the date in the ned. The visit date will be or the note. (Example - Provider.)
	Signature File Signature Signature Text Print Header External Id	Use the tag <signeddate> Signature Text the note was used unless there is an act Electronically Signed <signe Provider: Waiver Signed? (Used by extern</signe </signeddate>	elow if you wis considered sig al signed date fi edDate>	A to include the date in the ned. The visit date will be or the note. (Example - Provider.)

- 3. Select the Save button.
- 4. Select Close.

## 3.2.17 Range of Motion

The Range of Motion provides a default value for each item and allows the creation of a working value if the default values are not acceptable for your patients. You also have the option to disable items listed so that they do not appear on the questionnaire.

### 3.2.17.1 Edit a Range of Motion

#### 1. Select Administration > Range of Motion.

- Description Column: Name of the Range of Motion test.
- Default Value: The predefined value in the system.
- Working Value: Double-click the Working Value for the description to change and enter the new value.
- Disabled: Click this box if you want to remove an item from appearing under the Range of Motion exam.

🛃 RangeOfMe	ation			E	7 💌
Н					
Save	Description	Default Value	Working Value	Disabled ?	×
	Cervical				
X	Flexion	50	50		E.
Close	Extension	60	60		
01000	Lateral Flexion - Right	45	45		
	Lateral Flexion - Left	45	45		
	Rotation - Right	80	80		
	Rotation - Left	80	80		
	Dorsal				
	Flexion	90	90		
	Extension	25	25		
	Lateral Flexion - Right	25	25		
	Lateral Flexion - Left	25	25		
	Rotation - Right	25	25		
	Rotation - Left	25	25		
	Lumbar				
	Flexion	60	60		-
	1				

- 2. Make the necessary changes and select the Save button.
- 3. Select Close.

### 3.2.18 Reaction

This section is used for entering allergic reactions to medications. Patients may have allergic reactions to certain medications. This area allows those reactions to be entered in ahead of time so that you can just click on a reaction rather than have to type it in. This section assists you with setup for more information about use these reactions, please navigate to section <u>3.4.1 Patient Allergies</u> for more information.

#### 1. Navigate to **Administration > Reactions**.

Reactions		2 💌
	Reaction Type	Status
	Hives	Active
Close	Nausea	Active
New		
Edit		

2. Click the **New** button to enter in a new reaction.

💀 Edit Existin	ng Reaction		
<b>P</b>	Description:	Hives	
Save	Status:	Active	
Close			

# 3.2.19 Reports

The Reports Section will allow you to make changes to the way the heading appears when a note is printed and will allow you to create and edit custom letters that can be printed for patients or other doctors.

## 3.2.19.1 Reports Admin

1. Select Administration > Reports > Reports Admin.

妃 Report Adm	in				? <b>X</b>
	Header Information				
H	Location:	🔿 Left	Center	O Right	
Save	Print Phone #:	Yes	O No		
	Print Fax #:	Yes	O No		
X	Print Doctors Name:	Yes	O No		
	Print Address:	· Yes	O No		
Close	Print Patient Address:	Yes	🕐 No		
	Print External Ref #:	O Yes	Ø No		
	Body Information				
	Report Heading:	C Left	Center	O Right	
		V Bold	Italic	Vinderline	
	Section Heading	Left	Center	🕐 Right	
		Bold	Talic Italic	Underline	
	Sub Section Heading:	<ul> <li>Left</li> </ul>	Center	🔿 Right	
		📝 Bold	Talic	Underline	
	Closing:	Should you h hesitate to ca	ave futher question all this office.	is regarding the health status of this patient, please do not	-
	Footer Information				
	Footer Text	Confidential		V Print Patient Name In Footer	
	Open Report With		-		

- 2. Make any changes or configurations to the reports that print and click Save.
- 3. Select the **Close** button.

# 3.2.19.2 Letters

Letters can be pre-configured in ChiroWrite for easy creation. You can create new letter templates, edit existing ones and create letters tailored to your patients. Additional information can be reviewed by watching the Letters Video.

- 1. Select Administration > Reports > Letters.
- 2. Select **New** to customize the body of your letter.

ng Letter		-9- <b>14</b> 5
Letter Description:	Please Be Advised - MVA	
RE:		
Dear <%recipient_	te%> <%recipient_last_name%>,	6
<%patient title%> < motor vehicle acci	%patient first_name%> <%patient last_name%> came to see me on <%cases first_visit_dat ent that occured on <%cases.accident_dt%>. <%patient.he_she PC%> is complaining of:	te%> due to a
<%compaints_lette	_lst%>	
After evaluating <% orthopedic and new <%patient him_her	ation title%> <%patient last_name%> with range of motion studies, postural analysis and w clogical examinations, I have determined that <%patient he_she%> will need chiropractic ca i> from the effects of these symtpoms. My diagnosis is <%visits diagnostic_sentence%>.	arious rre to relieve a
I am treating this pa	ient with the goal of reduction of symptomatology. Specifically, my plan will consist of	
Sinhus erom he	Imani kasimani Salica	
< ability2_evdui_a.e	anair neannair isrie-	
If you have any furt	er questions, please feel free to contact me directly at my office for additional details.	
Available Tags: Cli	k link to insert into letter	
Chrecipient Hile%>	The title of the recipient	
<%recipient first na	The first name of the recipient	
s%recipient last nat	The last name of the recipient	(3)
<%patient title%>	The title of the patient	
Contient first name	C> The first name of the patient	
- Application of the local sector		

- 3. There are Available Tags at the bottom of the screen to assist you in creating a template letter for your patients.
- 4. Select Save.
- 7. Click Close when finished.

# 3.2.19.2.2 Edit Letter Template

1. Select Administration > Reports > Letters.

🛃 Letters		-2
	Description	
	Please Be Advised - MVA	
Close	Please Be Advised - Workers Comp	
	Thank you for referral - Detailed	
	Thank you for referral - Simple	
New		
Ede		
Lun		
Up		
. 🕹		
Down		
Down		

2. Highlight a letter to be changed and select **Edit**. There are **Available Tags** at the bottom of the screen to assist you in editing a template letter for your patients.

- 3. Make changes and then select **Save**.
- 4. Click **Close** when finished.

## 3.2.19.2.3 Print a Letter

- 1. Select a **patient** if you have not already done so.
- 2. Select the graph and stethoscope button for patient reporting.
- 3. Select Letters at the bottom of the reporting list.
- 4. Click Run and the screen below will appear.

+ Create New	w Letter						-V
<b>E74</b>	Letter:	Please Be	e Advised - MVA				
Close	Contact						
has been as a second	Title:	Dr.	<ul> <li>First Name:</li> </ul>		Last N	lame:	
-	Address Line 1:			Addres	s Line 2		
Create	City:			State.	AK	· ZIP:	
Letter	Re:						
	Dear <%recipien <%patient title%- to a motor vehicl <%compaints_le After evaluating « orthopedic and in relieve <%patien I am treating this <%phys_exam_t If you have any fi	It_title%> <% > %spatient le accident in titler_list%> c%patient tit eurological thim_her% patient with treatment tre unther quest	Srecipient_last_name%>, first_name%> <%patient last that occured on <%cases ac le%> <%patient last_name% examinations, I have determ > from the effects of these s the goal of reduction of sym eatment_list%> lions, please feel free to cont	t_name%> car coldent_dt%>. >> with range o inted that <%pa ymtpomas. My optomatology. tact me directly	me to see me o <%patient he_s f motion studie tient he_she% diagnosis is <br Specifically, m at my office fo	on <%cases.first_ she PC%> is com s, postural analys > will need chiropr &visits.diagnostic_ y plan will consist r additional details	visit_date%> due plaining of is and various actic care to _sentence%>.

- 5. Select a Letter from the drop down list you wish to use to create a letter with this patients information.
- 6. If you have contacts setup and the person you are sending the letter to is a contact select them from the Contact drop down.
- 7. Otherwise, fill out the necessary information.
- 8. Click Create Letter and the letter will be generated in Microsoft Word.
- 9. When finished, select Close.

## 3.2.19.3 Report Configuration

Additional information can be found by watching the Changing Report Names and Templates video.

- 1. Select Administration > Reports > Report Configuration.
- 2. Choose a **report** to make changes to and click the **Edit** button.

	Screen Title	Printed Report Title	Template file	
	SOAP Notes - COPY	SOAP Notes - COPY	StandardTemplate rtf	
se	SOAP Notes with exam	SOAP Notes with exam	StandardTemplate.rtf	
	SOAP Notes - Paragraph Style	SOAP Notes - Paragraph Style	SOAP.rtf	
	Initial Exam	Initial Exam	StandardTemplate.rtf	
-	Intermediate Exam	Intermediate Exam	StandardTemplate.rtf	
	Final Exam	Final Exam	StandardTemplate.rtf	
5	Dual Listing Examination Report	Dual Listing Examination Report	StandardTemplate.rtf	
_	XRay Report	XRay Report	StandardTemplate.rtf	
	V1 SOAP Notes - Paragraph Style	SOAP Notes - Paragraph Style	SOAP.rtf	
	V1 SOAP Notes - Detail	SOAP Notes By Dr. Greg House	TestTemplate.rtf	
	V1 Initial Exam	Initial Exam	StandardTemplate.rtf	
	V1 Intermediate Exam	Intermediate Exam	StandardTemplate.rtf	
	V1 Final Exam	Final Exam	StandardTemplate.rtf	

3. Select the screen title, printed title and which template ChiroWrite should use to create the report. Rich Text Files might be the best choice.

💀 Report Edit	t		7
	Screen Title:	V1 SOAP Notes - Detail	
Save	Printed Title:	SOAP Notes By Dr. Greg House	
	Template:	TestTemplate.rtf	
Close			

4. Click Save and Close , when finished.

## 3.2.20 Rooms

In ChiroWrite, you have the ability to differentiate between treatment rooms should you choose. This allows you to assign patients to treatment rooms or massage rooms during their check in process.

## 3.2.20.1 Create New Room

- 1. Select Administration > Rooms.
- 2. Select **New** to create a new room as shown below.



- 3. Enter in a Code that will help you easily identify the room.
- 4. Enter in a **Description** for the room.
- 5. Select Save.
- 6. Click Close.

- 1. Select Administration > Rooms.
- 2. Highlight the room you wish to edit and select Edit.



- 3. Make any necessary changes.
- 4. Select Save.
- 5. Click Close.

# 3.2.20.3 Assign a Room

1. Select Office Activities > Check In/Out

🚽 Check In/Ou	A			7 💌
	Last Name	First Name	Check In Time	Room
	McDuck	Scrooge	3:18 PM 2010-07-23	
Close				
In				
Assign				

2. Select the **patient** which you want to assign to a doctor and/or room and click the **Assign** button.

Checkin Assignments For : John Smith		
Room	Provider	Visit Reason
EX	Greg House	Conversion
MS1	Charles Neal, DC	Exam
MS2	Softworx Solutions	Final Exam
RM1		Initial Exam
RM2		Scheduled Visit
TX1		Unscheduled Visit
TX2		

3. Choose a room, provider and visit reason for this particular patient. You can choose all three or any combination of what you see.

- 4. Select **Save**, when finished.
- 5. Click Close.

## 3.2.21 Subluxation

The Subluxation areas can be added, edited, mapped, or the order can be changed to meet your needs. Through the system you can also create new subluxation listings and/or edit the items.

## 3.2.21.1 Create New Subluxation Area

#### 1. Select Administration > Subluxation > Areas.

Subluxatio	n Areas		-9-	*
	Area	Default	Sequence	1
	Cervical		1	
Close	Occiput		2	
	C1		3	
	C2		4	
New	C3		5	
	C4		6	
	C5		7	
Ede	C6		8	
CON	C7		9	
_	T1		10	1
istings	T2		11	
Aapping	T3		12	
	T4		13	
•	T5		14	
1	T6		15	
op	T7		16	
	T8		17	
Down	T9		18	

- 2. Click New.
- 3. Enter the Area.
- 4. Enter a Default value.
- 5. Select a Status of Active or Inactive.
- 6. Select the Save button.
- 7. Select Close.

## 3.2.21.2 Edit a Subluxation Area

1. Select Administration > Subluxation > Areas. The screen below will show up.

😔 Subluxatio	n Areas		-9-	
	Area	Default	Sequence	
	Cervical		1	
Close	Occiput		2	
	C1		3	
	C2		4	
New	C3		5	
	C4		6	
_	C5		7	
Edit	C6		8	
Lun	C7		9	
	T1		10	
Listings	T2		11	
Mapping	T3		12	
	T4		13	
•	T5		14	
	T6		15	
00	T7		16	
	T8		17	
Down	T9		18	

2. Highlight an area and click Edit.

Ч	Area:	C4	
Save	Default		
	Status:	Active •	
X			

- 3. Make the necessary changes and click the Save button.
- 4. Select Close.

## 3.2.21.3 Mapping Subluxation Area

- 1. Select Administration > Subluxation > Areas.
- 2. Highlight the listing and select the Listing Mappings button.

3. Highlight an item under the **Available Listings** in the right window. Click the **Left** or **Right** arrow to move the items back and forth between the two windows. If you would like to change the order of the items, highlight it and click the **Up** or **Down** arrow.

🛃 Options Typ	в		7 🔜
	Area: C1 Selected Listings		Available Listings
	Type	Sequence ^	Type
	A-L	1	AS
	A-LA	2	AS ilium =
	A-LP	3	AS-LS
	A-R	4	AS-LS-LA
	A-RA	5	AS-LS-LP
	A-RP	6 =	AS-RS
Up	AIL	7	AS-RS-RA
	AILA	8	AS-RS-RP
Down	AILP	9	ASEX
	AIR	10	ASIN
	AIRA	11	Body Left Spinous Right
	AIRP	12	Body Right Spinous Left
	ASL	13	BP
	ASLA	14	ESL
	ASLP	15	ESR
	100	10 *	<b>T T</b>

Tip: You can select more than one Available Listing by holding the Control button down while you click listings.

4. Select Close. Your changes will be automatically saved.

## 3.2.21.4 Change Order of Subluxation Areas

#### 1. Select Administration > Subluxation > Areas.

Subluxation	Areas		2
	Area	Default	Sequence
	Occiput		1
Close	C1		2
	C2		3
	C3		4
New	C4		5
	C5		6
	C6		7
Edit	C7		8
Euli	T1		9
	T2		10
Listings	T3		11
Mapping	T4		12
	T5		13
•	T6		14
	17		15
Op	T8		16
	Т9		17
Down	T10		18

- 2. Highlight the entry to move and click the **Up** or **Down** button.
- 3. Click the **Close** button when finished.

## 3.2.21.5 Create a New Subluxation Listing

		-	
V	Listing	Status	_ 6
<u> </u>	A-L	Active	
Close	A-LA	Active	1
15	A-LP	Active	
	A-R	Active	
New	A-RA	Active	
	A-RP	Active	
	AIL	InActive	
Edit	AILA	Active	
LUR	AILP	Active	
	AIR	Active	
	AIRA	Active	
	AIRP	Active	
	AS	Active	
	AS ilium	Active	
	AS-LS	Active	
	AS-LS-LA	Active	
	AS-LS-LP	Active	
	AS-RS	Active	

- 2. Click the New button and the window above will appear.
- 3. Enter the Area.
- 4. Select a Status.
- 5. Click the Save button.
- 6. Select Close.

## 3.2.21.6 Edit a Subluxation Listing

- 1. Select Administration > Subluxation > Listing.
- 2. Highlight the listing and click Edit.

De Edit Existi	ng Subluxation Li	sting	7
P	Area:	A-R	
Save	Status:	Active	
X			
Close			

Note: If you no longer want a certain subluxation listing to show up, change the status to inactive.

- 3. Select the **Save** button.
- 4. Click Close.

# 3.2.21.7 Prior Subluxations

To enable prior subluxations to be viewed, proceed with the follow steps. Take a look at the <u>Prior Subluxation Video</u> for additional assistance.

1. Administration > System Configuration > Defaults > Global 3 and click on Enable prior subluxations to be saved.

- 2. Click Save.
- 3. Click Close.

#### Note: You must exit the entire ChiroWrite system for changes to take effect.

The first time you click on a subluxated area, it will turn **green**, letting you know that area is currently subluxated. The second time you click it to turn off the subluxated area it will turn **yellow**, letting you know that this was a prior subluxation. The third time you click the subluxated area it will turn **white**, completely turning off the subluxated area letting you know there are no longer problems with it.

Area	Notes	^
Occiput		
C1		
C2		
C3		
C4		
C5		
C6		
C7		
T1		
T2		
T3		
T4		
T5		
T6		
T7		
T8		
Т9		
T10		

## 3.2.21.8 Subluxations on the Travel Card

To enable subluxations to be viewed on the travel card, proceed with the follow steps.

- 1. Administration > System Configuration > Defaults > Global 2 and click on Display Subluxations on Patient Travel Card.
- 2. Click Save.
- 3. Click Close.

Note: You must exit the entire ChiroWrite system for changes to take effect.

The travel card will now look like the one shown below.



## 3.2.22 Visit Reason

The system provides several default visit reasons which consist of: the consultation, exam, final exam, initial exam, scheduled and unscheduled visits. You have the ability to edit the existing visit reasons or create new ones using the directions outlined in this section.

## 3.2.22.1 Create a New Visit Reason

- 1. Select Administration > Visit Reason.
- 2. Click **New** and the window below displays.



- Tip: The Description and Status fields are required to add a new Visit Reason to the system.
- 3. Enter the **Description**.
- 4. Select the Workflow type from the drop down menu.
- 5. Select the radio button next to Exam or SOAP.
- 6. Choose Initial, Re-examination or Final examination from the drop down menu.
- 7. Select Status as Active or Inactive.
- 8. Click the Save button.
- 9. Select Close.

- 1. Select Administration > Visit Reason.
- 2. Highlight the visit type and click Edit.

-	Description:	Initial Exam		
Save	Workflow:	Standard Template		
-	Visit Type:	• Exam O SOAP	Initial Examination	-
X	Duration:	30		
Close	Color Code:	Firebrick	•	
	Status:	Active		

- 3. Make the necessary changes and select the Save button.
- 4. Select Close.

## 3.2.23 System Configuration

The System configuration allows you to do the following:

- Setup System Defaults
- Configure Custom Reports
- Create and Edit System User Profiles
- Backup and Restore Data
- Import and Export Data

Remember changes made to the system defaults will take place once you have exited the system and logged back in.

## 3.2.23.1 Default System Configuration Options

The system configuration allows you to make changes to the Global, Global 2, Global 3, Global 4, SOAP, Printing, Scanning, Copy Options, Patient Check In and Misc windows. Below are instructions on how to access these options and also screen shots of all six options so that you can better see what items are customizable in this menu.

- 1. Select Administration > System Configuration > Defaults.
- 2. After making changes to the menu, click Save.
- 3. Select Close.

## 3.2.23.1.1 Global 1

The configuration that takes place under the Global 1 tab is as follows:

System Set	tings		V- 10.00
m	Global 2 Global 3 Global 4 SOAP SOA	P 2 Printing Scanning Copy Options Patient Check In	Misc.
Save	Display the following when entry fields are double Notes Phrases	clicked/tapped on:	
	I Display Patient Travel Card on selection of new	patient	
Close	I Use Universal Network Paths (Recomended)		
and the second second	My Picture 1 Path:		
	My Picture 2 Path:		
	My Picture 3 Path:		
	My Picture 4 Path:		
	My Picture 5 Path.	(*)	
	System Path:		
	Copy image drawings from visit to visit		
	If you have images that are in folders by the Patier to have those images show up in ChiroWrite, indic	nt Id in your billing system and you wish ate the path to those images below	
	Existing Images Path:		
	Auto Load images when patient selected		
	R Auto select Current Patients when Home button	is pressed	
	Hide SSN in search results on Search window     Enable Visit Surfing	Hide Phone # in search results on Search window	
	E Travel card subluxations full length	Subluxations font size	

1. Display the following when entry fields are double clicked/tapped on: this gives you the ability to use worxphrases when you double click.

2. My Picture 1-5 Paths allow you to view images that you can then draw on in the ChiroWrite system.

3. Copy image drawings from visit to visit will copy what you've drawn from visit to visit. If this is not checked drawings will not copy.

4. Auto select Current Patients when Home button is pressed will take you out of all the patient files and open up Current Patients so the next patient to work with can be selected.

5. Hide SSN in search results on Patient Search window will hide the SSN from the list that is shown.

Constanting of the	C						1
Close	Last Name:			🖌 Sort By	Last     First	Name Name	
Pearch	SSN:		•	Status	_		
	ABC	DEF	GH		K	L	M
	NOP	QRS	TU	V W	X	Y	Z
	Matching Patients						
Select	Last Name	First Name	Address		SSN		

6. Enable Visit Surfing will give you access to move through visit to visit. Learn more by watching the Visit Surfing video.

SOAP .	Subjective		(= 3/11/2011	
SOAP     Subjective     Objective     Objective     Assessment     Plan     Today's Treatments     Charges     Diagnosis     SOAP Custom     SOAP Custom     SOAP Custom     SOAP Custom     SOAP Custom     Body Picture     Body Picture     Whole Spine Picture	New Condition       Overall Pain Today:     0 0 1 0 2 0       Overall Health Today:     0 1 0 2 0       1. Left Shoulder <details avail<="" td="">       Feeling:     * Betler     Sam       Pain Today:     0 0 1 0 2 * 3       2. Lower Back     <details availa<="" td="">       Feeling:     Betler     Sam       Pain Today:     0 0 1 0 2 * 3       2. Lower Back     <details availa<="" td="">       Feeling:     Betler     Sam       Pain Today:     0 0 1 0 2 * 3</details></details></details>	3         +4         5         6         7         8         9           3         -4         5         6         7         8         9           3         -4         5         6         7         8         9           able>         Worse         Show Details         5         0         4         5         6         7         8         9           ble>         -         -         -         -         8         9           ble>         -         -         -         -         8         9           ble>         -         -         -         -         8         9	3/11/2011 2/7/2011 1/28/2011 1/28/2010 12/10/2010 12/10/2010 12/9/2010 12/1/2010 10 (12/1/2010 11/4/2010 6/17/2010 10 (5/21/2010	
	3. Bilateral Posterior Neck Feeling: Better Sam Pain Today: 0010203 Comments:	e o Worse Show Details	Edit Details 10 (Excruciating)	

7. Travel Card subluxations full length will show subluxations on the travel card as shown below. You also have the ability to choose font size for that. Learn more by watching the Expanded Subluxation List on the Travel Card video.

And There Cell Treadmonts The Cell Treadmonts	) 🗊 🖬		8/1	Total Visite: 265 Last Visit Extern No.	What's Ne	w2 🕑		
And and a second more that the	use Wayne X							
Nome       Summary 2 History Transfs [Notes ]       Claims       Personal typey, Last 592012, First 292010         Nome       Visits: Sel / 30       Visits: Sel / 30       Image: Sel / 30       Image: Sel / 30         Nome       Visits: Sel / 30       Image: Sel / 30       Image: Sel / 30       Image: Sel / 30         Nome       Visits: Sel / 30       Image: Sel / 30       Image: Sel / 30       Image: Sel / 30         Nome       Visits: Sel / 30       Image: Sel / 30       Image: Sel / 30       Image: Sel / 30         Nome       Visits: Sel / 30       Image: Sel / 30       Image: Sel / 30       Image: Sel / 30         Odep       Image: Sel / 30       Image: Sel / 30       Image: Sel / 30       Image: Sel / 30         Odep       Image: Sel / 30       Image: Sel / 30       Image: Sel / 30       Image: Sel / 30         Odep       Image: Sel / 30       Image: Sel / 30       Image: Sel / 30       Image: Sel / 30         Neme       Image: Sel / 30       Image: Sel / 30       Image: Sel / 30       Image: Sel / 30         Odep       Image: Sel / 30       Image: Sel / 30       Image: Sel / 30       Image: Sel / 30         Image: Sel / 30       Image: Sel / 30       Image: Sel / 30       Image: Sel / 30       Image: Sel / 30         Image: Sel / 30       Image:	atient Travel Card							EK.
Keen     Keen     Name       Geboord     2     Visits: Soir 20     Visits: Soir 20       Geboord     2     Visits: Soir 20     Visits: Soir 20       Goord     2     Visit: Treatments.     7       Time     10     10     7       Cite     Spanal Adjustment     7       Cite     7     8       Cite     7     8	Charlen I	Summa	ry 2 History Tr	rends Notes	Case	es: Personal I	njury, Last 5/9/2012	2, First 2/9/2010
Kam         Last Visit Treatments         TT         TH           Area         L/R.B         Treatment         TH           C1         Cm         Sprail Adjustment         TH           LS         Left         Sprail Adjustment         TH           L3         L3         L3         L3           L4         Sprail Adjustment         L3         L3           L3         L3         L3         L3           L4         Sprail         Store         Store           L4         Store         Store         Store           L4         Store         Store         Store           Store         Store         Store         Store	Yoz OAP coday	Mail Walts S			Centors Cri Decont Cri Cri Cri Cri Cri Cri Cri Cri Cri Cri	+ Chiefs Deta 1. R Para	Complaint(s) its profiles profiles the complaint its profiles the complaint	
Lake Visit / Featments         %           Area         UP/8         Treatment         10           Area         UP/8         Treatment         10           1         Lot         Spraid Adjustment         11           15         Lot         Spraid Adjustment         12           12         13         12           13         14         14           14         15         Spraid Adjustment         13           13         12         13         14           14         15         Spraid Adjustment         14           15         Lot         Spraid Adjustment         15           14         Spraid Adjustment         15         14           15         Spraid Adjustment         15         14           16         Spraid Adjustment         15         14           15         Spraid Adjustment         16         14           16         Spraid Adjustment         16         17           179         Spraid Adjustment         16         16           14         Spraid Adjustment         16         16	and Locald	and Transferra			77			
Predict         Links         Homosove         Tip           C1         Cdit         Spinal Adjustment         Tit           L3         Lot         Spinal Adjustment         Li           L4         L3         L3           L6         L4         Second Adjustment         Second Adjustment           L3         L3         L3         L3           L4         Second Adjustment         Second Adjustment         Second Adjustment           L5         Second Adjustment         Second Adjustment         Second Adjustment	oday Lasty	ISIL TREADING	THES.		73			
Unit         Diagnosis           LS         Left         Spinal Adjustment         L1           L3         L4         L3         L3           L4         L3         L3         L3           L4         L3         L3         L4           L5         L4         Spinal Adjustment         L1           L3         L3         L3         L3           L4         L3         L3         L4           L5         L4         Spinal Adjustment         L4           L3         L3         L3         L4           L4         L3         L4         L4           L4         L4         L4         L4           L5         L4         L4         L4           L4         L4         L4         L4           L5         L4         L4         L4           L5         L4         L4         L4           L5         L4	C1	LINB	Creating Advert		710			
Unit         Unit <th< td=""><td>01</td><td>Lat</td><td>Sound Adjust</td><td></td><td>Int</td><td></td><td></td><td></td></th<>	01	Lat	Sound Adjust		Int			
12 13 14 14 15 15 15 15 15 15 15 15 15 15 15 15 15	15	1.94	open of Polpose		0			
L1         Diagnosis           L4         840.9         5629/2010         Ann/Nhoulder S           Barry-Joint         719.4         5829/2010         Hip Pain           Barry-Joint         31         Hip         Hip	15				12			
L4 and the second method of the second method method of the second method method method of the second method metho	1.5				ci (	Diagon	nsis	
IS Device the provide the providet the	15				14	840.0	58.30/2010	Annishcutifar Corp.
Berghan Barg-Jam 11	15					040.0	00-4-62010	Ministration of the
	15				1.9	719.4	58 - 29/2010	PED Pain
The second	15				Secure Secure	719.4	58+2592010	Hip Pain
Lindersand With Mail Lines	15				Sachum Sachum Sachu-Jaant 21	719.4	56+2/9/2010	Hip Han

8. Hide phone number in search results on Patient Search window will hide the Phone number from the list that is shown. Learn more about this by watching the <u>Hide Phone Number in Search Window</u> video.

Nose	Search Criteria Last Name:						*	Sort B	ly:	• Las	it Name st Name	
Pearch	SSN.							Status	es,			-
	ABC	D	E	F	G	H				к	L	M
	Matching Patients	q	I K	5		0	V	W		X	Y	12
elect	Last Name	Fi	rst Name	,	Addre	155				Ph	one	

## 3.2.23.1.2 Global 2

The configuration that takes place under the Global 2 tab is as follows:

*/ System Se	etings -0 - Market
Save	Global 3       Global 4       SOAP 2       Printing       Scanning       Copy Options       Patient Check In       Misc.         Adjustment Default       •         Adjustment Default       •         Rehab Default       •         Default Exam Workflow.       •         Default SOAP Workflow       •         ROM Default       •         ROM Default       •         Adjustment with to display selected images instead       •
	of the Contra Indications on the Patient Travel Card  © Display Images instead of the Contra Indications  Save "Medical Assist" into Medical Closing field Enable Canadian Settings Display subtuxations on Patient Travel Card Display My Notes instead of image drawing on Patient Travel Card Subside My Notes instead of image drawing on Patient Travel Card Auto check out patients when Note is indicated as Complete Show external patient number on main screen Order Treatments on Travel Card & Today's Treatments by Area Treatment Type (Adjustments, Adjunctive, Rehab) and area Order Enter Order Charges: Procedure Code Order Entered Enforce Computer time within 5 minutes of each other

1. The default combo boxes for adjustment, adjunctive and rehab are all used so that you can decide which treatment to begin the list on in your Today's Treatment's screen.

2. The default combo boxes for exam and SOAP worxflows designate which worxflow to begin on when you click your Exam Today and SOAP Today buttons.

3. ROM Default will determine what is first shown to you on the ROM pages. The inclinometer side of things deals with degree values and the visual side of things will give you drop down boxes. You can also choose to set pain to "No" when you select your default button. Learn more by watching the <u>ROM Default - Pain Default "No" Added</u> video.

4. Display Images instead of Contraindications means that the contraindications will show up on the travel card instead of images as shown below.

		Total Visits: 38 Last Visit 3/1	2011	What's New?	ĉ
Patant To	and Card Summary 2 History Trends N	otes Case	Lower Back, Las	3/11/2011 Fest 2/11/2010	1
х	LastExam 11/10/010	Visits: 74 Subl	mations	Chief Complaints)	
Close		Area	Notes	Details	
	19 A. 19	C2 C5		1. Lower Back Pain Level 5	
Visit Dates	A CO	4 T4		2. Left Shoulder Pain Level. 5 3. Headaches Pain Level. 6	
OAP	B (A)	Cont	a Indications		
		36,861.9	and the second second		
Exam	Area LR/B Treatment	1 55775	PROPERTY AND ADDRESS		
ixam oday	Area URVB Treatment C2 Ent Spinal Adjustment C5 Floght Spinal Adjustment T1 Blaterah Spinal Adjustment ShoulderElectrical Stanulation	Diag	10585		
Exam Foday	Area         L/R/B         Treatment           C2         Extl         Spiral Adjustment           C5         Right         Spiral Adjustment           T1         Baterah, Spiral Adjustment           Shoulder         Right         Electrical Streaktion           80-120 freq @ 25volts         25volts	Diag 724.5 739.3 307.81	10585 74 - 2/11/2010 71 - 5/5/2010 72 - 2/11/2010	Acute Low Back Pain NOS Lumber Sublexation Tension Headache	

5. Save "Medical Assist" into Medical Closing field means that the medical history will be saved in the closing section so that you can use the middle section for anything additional you want to type or use in worxphrases.



6. Enable Canadian setting will setup the system to use the time and date formats that they use in Canada.

7. Display subluxations on travel card will display any subluxations that your patient has on your travel card. You can see an example of this on the travel card shown above or below.

8. Display My Notes instead of image drawing on patient travel card will do just that. It will show your my notes section instead of the image of the body that you draw on.



9. Auto check out patients when Note is indicated as complete will check patients out of ChiroWrite so that they no longer show up on the Current Patients list.

10. Show external patient number on main screen will show the patients number that they have from the external billing system. This will show up below their name.

- ChiroWrite				- 0 -×-
File Administrat	tion Office Activities	Patient Activities (	Current Patients Help	
8 🌆	) 🌆 📥	- /	Patient Bruce Wayne Total Visits: 98 Last Visit: 3/11/2011 Extern No: WA01334	What's New? 🚱 🏠

11. Order Treatments on Travel Card and Today's Treatments will either group treatments together or list the treatments in

alphabetical order by area. In the travel card image above they are ordered by treatment.

12 Order charges will either group together the charges as they were entered or by their number depending on which option you choose.



The configuration that takes place under the Global 3 tab is as follows:

System Se	ttings			11	-88-
100	Global   Global 2 Global 4	SOAP SOAP 2	Printing Scanning	Copy Options   Patient Check In	Misc.
	Current Patients Default Sort Order:	Patient Name	O Time In		
Save	Incomplete Notes Default Sort Order:	C Visit Date	C Patient Name	O Provider	
х	Current Patients Name Display:	Full Name     Incomplete No	First & Initial tes should follow this	Initial & Last rule also	
Close	On Exit, ask if notes are complete:	· Always	<ul> <li>Only if note was</li> </ul>	marked incomplete	
	Launch Assignments after patient of	theck-in (Room, P	rovider, Visit Reason	0	
	Do NOT show missed checked-in a	appointments			
	Default Diagnosis Category:			-	
	Default Charges Category:			-	
	Print Provider Signature on: O Soap	Notes 💿 Narra	tives 🜻 Both		
	I Enable erase screen option (Enable	es the erase scree	en button on the worl	kflow windows)	
	Use the term "Joint Dysfunction" in	stead of "Subluxat	ion"		
	Enable Scenarios (System will ask	if you wish to cop	y predefined Visit Sc	enanos)	
	Enable prior subluxations to be save	ed	22 N.262		
	2 Ask exam type when Exam button	is clicked on Patie	nt Travel Card		
	Ask SOAP type when SOAP buttor	1 is clicked on Pati	ent Travel Card		
	Nick Name Rule - how to display the	patient name if the	ry have a nick name		
	Replace First Name with	Nick Name (does	not effect reports)		
	Combine Nick Name int	o patient name (do	es not effect reports	)	
	Do Nothing				

1. Current patients in default sort order either by patient name or time they came in will sort the patient names in the Current Patients section by the selection you make.

2. Incomplete notes default sort order either by visit date, patient name or provider will sort the patient names in the incomplete notes section by the selection you make.

3. Current Patients name display will show your patients full name, their first name and their last initial, or their first initial and their last name. You can also choose to have the incomplete notes section follow this selection as well.

4. On Exit, ask if notes are complete always or if note was marked incomplete will give you a pop up box upon exit to make a distinct selection on whether you are done with your note or not.



5. Launch Assignments after patient check-in will launch the screen below so that additional information can be added on the current patients screen.



6. Do not show missed checked in appointments will do just that. If a patient has been checked into a billing system and they really missed the appointment and are checked out they will not be shown in the check in area.

7. Default Diagnosis and charges Category will begin the respective pages on the default category that you have selected here.

8. Print providers signature on will allow you to determine whether your signature, if in ChiroWrite, gets printed on the SOAP Notes, the Exam Notes or both.

9. Enable erase screen option will give you an extra icon that looks like a lightning bolt in the worxflow windows that will allow you to erase what's on the screen.

10. Use the term joint dysfunction instead of subluxation will use joint dysfunction instead of subluxation throughout the system as well as in your printed reports.

11. Enable patient scenarios will allow you to setup predefined exams that you can use to copy to any patient exam. For instance, if you see a lot of low back patients you can create an exam with all that data that you would simply have to adjust to the specific patient you are working with.

12. Enable prior subluxations to be saved will allow you to view subluxations that may have previously been a problem, but are no longer a problem. Previous subluxations will be highlighted in yellow instead of the common green color. Learn more by watching the Subluxation History video.

13. Exam type when exam button is clicked on via the travel card will pop up a screen that asks you what type of exam you are completing.

Close	Initial Exam	
	Exam	
Select	Final Exam	

14. SOAP type when SOAP button is clicked on via the travel card will pop up a screen that asks you what type of SOAP you are completing.

15. Nick Name Rule will allow you to display your patient's nickname on the travel card if you choose to do so. The nickname will not print in your reports, but is mainly just for your reference.





The configuration that takes place under the Global 4 tab is as follows:

100	man all days and man		1. P
and a second	Global   Global 2   Global	3 GUODE SOAP   SOAP 2 Printing   Scanni	ng Copy Options Patient Check In Misc.
	Allow multiple patient	s to be open at the same time 🛛 📃 Single close	box for all pages, not on indivual tabs
Save	Do NOT print SOAP for all patients	opening sentence about patient being evaluated	for care plan
X	😢 Show subluxation/join	t dysfunction items first in the list	
Close	Z Make assigned provi	der the treating provider of the encounter	
	I Make logged on prov	rider the treating provider of the encounter	
	Motor Vehicle accident	abel . Accident Collision	
	1-2 region charge:	98940/ - Manipulation/1 to 2 Regions	-
	3-4 region charge:	98941/ - Manipulation/3 to 4 Regions	
	5 region charge:	98942/ - Manipualtion/5 Regions	•

1. Use Classic Single Patient vs. Multi Patient will allow you to use ChiroWrite the original way, one patient at a time rather than multiples. Learn more about the multi patient option by watching the <u>Multi Patient File Option</u> video.

2. Do NOT print SOAP opening sentence about patient being evaluated for care plan is now a global setting in addition to it being a patient by patient setting. Making the selection will not print the sentence that opens the subjective section stating that the patient was evaluated today to determine progress and response to the current treatment plan.

3. Show subluxation/joint dysfunction items first in the list means they are at the top of the list when you navigate to the subluxation screen, like the right side.



4. Make assigned provider the treating provider of the encounter means that if a provider is assigned to a patient when checked in, the assigned provider will be the treating provider for the note that is created. Learn more about the treating provider defaults by watching the <u>Treating Provider</u> video.

ave	Room	Provider	Visit Reason
_	EX	Melani Crocker, DC	Conversion
XII	MS1	Greg House, DC	Exam
ose	MS2	Charles Neal, DC	Final Exam
_	RM1	Marco Polo, D.C. D.O	Initial Exam
	RM2	Softworx Solutions, DC	Scheduled Visit
	TX1		Unscheduled Visit
	TX2		

5. Make logged on provider the treating provider of the encounter means that if a provider is logged in as himself or herself then they will be the treating provider for the note that is created.

	Today's Treatmen		C 🖉 🌆 📥 5/10/2012 - 🛋 🧧
	Today's Treatment		
	Tog AP Lit	Spine Extrem Other	Notes Log Wy Notes
and .	L Area To R	L Area To R	# Adjustments @ Adjunctive Therapy @ Rehab
-	Cervical .	1 10 I I I I I I I I I I I I I I I I I I	Onigal Adjustment
	00	C T0	opinal Adjustment
	C1 01	C T10	0
pero .	C C2 P-SP-INI	D T11 D	
om 2	Cl	C T12	Add Hellove Hellove Al
ALTES .	0.04	🗋 Lumber 📄	Treatments Performed
	L CS	EU 0	Area LURIE Treatment
	00	0.0	C1 Sonal Adustment
Picture	07	00 0	L5 Left Sonal Adustment
	Thoracic	04	
	011	D.U	
	172	D Sacrum D	
	0.13	D Bum	
	14	D Sacro-A	
	10 10	5 60	
		10 84 D	
	11 H	D VE D	and the second sec
		10.00 D	Y Commenter and Y
			Treatments O No Pain O Moderate Pain
			Tolerated
			with a Mat Pan O Significant Pain
			Treating Provider Solutions, DC, Softwork

6. Motor vehicle accident label means that you now have a choice between accident or collision as the descriptive word that is used in the accident assist area.



## 3.2.23.1.5 SOAP

The configuration that takes place under the SOAP tab is as follows:

💀 System Set	lings		
	Global   Global 2   Global 3   Global	al 4 SOMP SOAP 2 Printing Scanning Copy Options Patient Check In	Misc.
Save	Display a scale from 1-10 on the screen representing:	SOAP Subjective	
	2 Overall Pain		
X	🗵 Overall Health		
Close	Select the level that you wish pat visit. "Minimal" will copy Pain Ra Selecting "All" will copy all inform such as Radiating and Pallative.	ient complaint data to be copied from visit to ting and Subjective (Better/Same/Worse) ation entered including comments and details	
	O Minimal # Al		
	Open SOAP Objective to Sub	luxation Tab	
	Enable "Remove All" button o	n Today's Treatment screen	
	2 Display Listings on Today's Tr	eatment screen	
	Z Auto select all subluxation are	es on Today's Treatment screen	
	Treatment Areas: Do not allow	r long names to carry over into op down box will show	
	E Show Listings only in Today's	Treatments in 'To' list	
	Enable Dual Treatment areas	on Today's Treatments	
	Start Spine 2nd List At:	T8 *	
	Start Extremity 2nd List At	Hand -	
	Start Other 2nd List At	-	
		0	

1. Select the level that you wish patient complaint data to be copied will allow you to select between minimal and all. Your system is set to minimal to begin with. This will copy over the pain rating and the subjective. Choosing all will copy additional information including where the pain might be radiating or what makes it better or worse.

2. Open SOAP Objective to Subluxation Tab will begin your objective section on the subluxation tab rather than the cervical tab.

3. Enable "Remove All" button on Today's Treatment screen will allow you select the remove all button which removes all the treatments from the Treatments Performed list.

4. Display Listings on Today's Treatment screen will allow you to display and use the listings in your listing section on the Today's Treatment screen.

5. Auto select all subluxation areas on Today's Treatment screen will automatically select any subluxation areas that have been highlighted by you on your treatment window. In the image below, you can see how you can choose listings and you'll notice that three vertebra are already selected. Those are the automatic selections from the subluxation area.

? 🗊 🗐 🗳	8	T3 T4 T5	tal Vester 1 tern No.	P Last Viel	yne 3/14/2011	01	Y	Vhat's New?	8
sowp -	Today's	TE	1	1	33	1 4	4	3/14/2011	
Subjective Objective Objective Objective Plan Today's Treatments Charges Diagnosis SCAP Cestom 2 SCAP Cestom 2 SCAP Cestom 3 Picture Picture Obly Picture Cenical Spine Picture Whole Spine Picture	Tog         A           L         Area           Corridal         CO           C1         C2           C2         C4           C5         C6           C7         Thorack           T0         T3	17 17 17 17 17 17 17 17 17 17	Spre Area 79 710 711 712 Lumb L1 L2 L3 L4 L4 Sacro Sacro	Extrem To	R	Adjustme Spinal A Add Treatments Area C5 T1 Shoulder	Notes Adjust	Log My Not Adjunctive The iment Remove ned Treatment Spinal Adjustit Spinal Adjustit Electrical Stim 80-120 freq @	es   wapy © Rehab Remove Al lent ent ent ulation Zévots
	0 T4 0 T5 0 T6 0 T7		0 S1 0 S2 0 UE 0 LE		000	r Treatments Tolerated With: Treating Pin	an ovider	• No Pain Mild Pain	<ul> <li>Moderate Pain</li> <li>Significant Pain</li> </ul>

6. Treatment Areas: Do not allow long names to carry over into "To" column so that listings in the drop box will show. If we look at the image above, under sacrum, you will see sacro-joint and it's cut off to allow listings to appear in there and be utilized by the doctor.

Show listings only on Today's Treatments in "To" list will only show the listings and not the other vertebrae you can choose from.
 Enable Dual Treatment Areas on Today's Treatments will show you the treatment areas in a two column listing as it shows you in the image above. Otherwise the left hand side is going to be images of the spine that you can draw on. Review the <u>Dual Treatment</u> <u>Areas Video</u> for further information.

## 3.2.23.1.6 SOAP 2

The configuration that takes place under the SOAP 2 tab is as follows:



1. Default image on Today's Treatments to LATERAL will allow you to change the image to another one, if you choose.

For additional information on this system feature, review the Dual Image Video provided.

## 3.2.23.1.7 Printing

The configuration that takes place under the Printing tab is as follows:



1. Print Treatment Plan always on SOAP in plan section will always print the plan instead of just proceed with therapies as directed.

2. Print Treatment Purpose when printing Treatment Plan will print the purpose of why you perform each treatment if it was included in your treatment plan. This will happen in parenthesis after the treatment is named.

3. Print linked Diagnosis when printing Treatment Plan will print the diagnosis followed by the treatment that is planned for that diagnosis.

4. Print Today's Treatments in Narrative Reports will include the treatments you performed on the same day as your examination in the Today's Treatments section.

5. SOAP Range Printing allows you to determine if you would like the range of soap notes that are printing to be printed starting with the most recent visit and working backwards OR starting with the oldest and working forwards.

6. Print subluxations on Exam reports will print the subluxation complexes on the exam reports.

7. Print subluxations on SOAP notes will print the subluxation complexes on the SOAP notes.

8. Print subluxation notes on reports will allow any notes that you have added on the subluxation screen to print into your notes.

9. Print Outcome Assessments in SOAP Notes will allow the score and answers of the outcome assessment taken to show up in your SOAP note.

10. Print Social Security Number with patient information will print the patient's SSN in the patient information header on the SOAP note or narrative.

11. Print Date of Accident with patient information will print the date of accident in the patient information header on the SOAP note or narrative.

12. Print Insurance Company Name with Claim Number will print the insurance company name and claim number, if provided, in the patient information header on the SOAP note or narrative.

SoftworxD630 370 CenterPointe Cir Suite 1166 Altamonte Springs, FL 32701 800.642.6082 Provider: Softworx Solutions

John Smith 5465 Whitehall Rd Orlando, FL 45657

SSN: 555-55-5555 Date of Injury: 5/10/2010

Blue Cross Blue Shield Claim# ZKG544656

#### SOAP Notes - Detail

#### 3/11/2011

#### Subjective Complaint

Mr. Smith was assessed today for progress and response to the plan of care. The patient was asked about his pain levels which he rated as follows: Overall pain level today on a scale of 0 (no pain) to 10 (unbearable pain) is considered a 4. Overall health on a scale of 1 to 10 is rated as 6. Today the patient says there are improvements in his left shoulder. During today's visit, the patient reported that his lower back showed no change since the last visit. On a scale of 0 to 10 with 10 being the worst, he rated his left shoulder as a 3 and lower back as a 3. The patient also noted the following about his symptoms: "Left Shoulder - According to the natient" the nation is mild to moderate.

13. Print providers signature on will allow you to determine whether your signature, if in ChiroWrite, gets printed on the SOAP Notes, the Exam Notes or both.

Today's treatment included spinal adjustment at C1 on the left and at L5 on the left. The patient tolerated these treatments with mild pain. Today, Mr. Wayne was advised to take suppliements Fish OH, Vitamin C and Calcium. Today, Mr. Wayne completed exercise protocol 1 for upper extremity focusing on the right shoulder. He completed this with 15 pound dumbells. Today, Mr. Wayne received interential treatments on his neck and upper back, cervical, thoracic, lumbar and sacrum and pelvis. The TEST2 was completed to the L2. TestPoints: C2.



14. Print Diagnosis in Assessment area of SOAP note will print the diagnosis information in the assessment area of the SOAP note rather than the Today's Treatments area.

15. Print Log in Today's Treatment area will print the exercise log in the Today's Treatment area of your SOAP note. Here you can also change the title of your log.

16. Do NOT print examination dates when printing SOAP range stops the examination dates from being printed as SOAP notes when printing a range of notes. You currently cannot print proper examination notes with SOAP notes in a range format.

### 3.2.23.1.8 Scanning

The configuration that takes place under the Scanning tab is as follows:



1. Scan device shows the device that you are using as your scanner. Clicking the Get Devices button will show this information.

2. Scan path is the area where your scanned documents will be stored.

Note: Please make sure your scanned documents are saved in a shared folder that all computers can view on the network otherwise you will see can't load as shown below.

1	9 29	-		ExternNo			
in Smith	*						
trant Th	Nel Card						
	Sec. Sec.	Summary	2 History Trends No	otes.	Case	Inknown Last 4/26/2012, First 5/21/2010	
ose		U	-3.0 P	R.A.		Can'lLoad	
ves XAP day					Subfunctions Area Notes 10 110 L2 L4	Chief Complain(b) Details 1 Balancel Lower Back Oreas, DASET Servery, Mills to Moderate, Pain Level 2. Mid Back	
huit alles DAP xday	Last Visit	Treatmon			Subluxations Area Notes 10 11 110 12 14 15	Chief Complain(b) Details 1 Balancel Lower Back Oracle OASET Serverity: Mid to Moderate, Pain Level 2. Mid Back	: 3
hut Wes XAP day day day	Last Visit	Treatmen			Subluxations Area Notes T0 T10 L2 L4 L5	Chief Complain(b) Details 1 Hataria Lower Bock Details Serverly: Mid to Moderate, Pain Level 2. Mid Back	
nit Res XAP day day day	Last Visit Area L5	LRB	E Treatment Scene Adjustment		Subfuxations Area Notes T10 L2 L4 L5	Chief Complain(b) Details 1. [Material Lower Back Onset: DESET Serverity: Mits to Moderate: Pain Lower 2. Mid Back	: 3
nit Res AP day am day	Last Visit Ana L5 T10	LRB	65 Treatment Spreak Adjustment Spreak Adjustment		Subfuxations Area Notes T0 T10 L2 L4 L5	Chief Complain(b) Details 1. Internet Lower Rack Onset: Office E Serverity Mild to Moderate, Plan Level 2. Mid Back	•
net Res XAP day am	LastVisit Ania L5 T10 T9	Treatmen LIR®	E Treatment Sprad Adjustment Sprad Adjustment Sprad Adjustment		Subluxations Area Notes T0 T10 L2 L4 L5	Chet Complain(b) Details 1. Bitward Lower Back Onset: OKSET Seventy Mid to Moderate, Pain Lower 2. Mid Back	: 3
nd Res XAP day am day	Last Visit Area LS T10 T9 Lumbar	<u>Treatmen</u> LR®	6 Treatment Speak Adjustment Speak Adjustment Speak Adjustment Directical Stimulation 15 minutes	(P)*	Subfuxations Area Notes T0 T10 L2 L4 L5 Diagnosis	Chief Complain(b) Details Details Creat Const Const Const Const Const Const Const Const E Serverity Mild to Moderate, Plan Level 2. Mid Back	
hat Wes day day day	LastVisit Ana LS T10 T9 Lumbar Lumbar	Treatmen LRS	E Treatment Spreat Adjustment Spreat Adjustment Dectived Stanuation 15 minutes cold packs		Subfuxations Area Notes T10 L2 L4 L5 Diagnosis E02 12 e0140001	Cheld Complain(b) Details 1. Butwert Lower Back Onset: OKSET Severity Mid to Moterale, Pain Lower 2. Mid Back	. 3
hat XRes XAP xday xday	Last Visit Ana LS T10 T0 Lumbar Lumbar Thoraco	Treatmen LIR®	5 Treatment Spinal Adjustment Spinal Adjustment Dectrical Strutution 15 minutes old packs old packs	Ø,	Subfuxations Area Notes T0 T10 L2 L4 L5 Diagnosis 809.2 12 - 0.162011 709.2 5-0.242013	Chief Complain(b) Details Details Create Lower Back Create Lower Back Create Lower Back Create Lower Back 2. Mid Back 2. Mid Back	1.3

3. Compression and Scan Protocol are things that the ChiroWrite technical support staff uses to help get your scanner working correctly, if needed.

4. Enable logging is a feature that the ChiroWrite technical support staff uses to help get your scanner working correctly, if needed.



The configuration that takes place under the Copy Options tab is as follows:



1. This page is used for the doctor to determine which areas of the SOAP note he/she would **NOT** like to copy from day to day.

For additional assistance, please view the No Copy Option Video.

## 3.2.23.1.10 Patient Check In

The configuration that takes place under the Patient Check In tab is as follows:

Global 2 Global 2 Global 3 Global 4 SOAP SOAP 2 Printing Scanning Copy Options         Extent Check In           Save              % Enable Patient Check-In               when patients scan their ID card at a provider workstation, open:	Misc.
Save Enable Patient Check-In When patients scan their ID card at a provider workstation, open:	
Save When patients scan their ID card at a provider workstation, open:	
C Patient Travel Card	
Close SOAP Note for Today	
Scanner Prefoc	
Scanner Suffix:	

1. Enable Patient Check-In will allow you to use the kiosk, if it has been purchased and we have installed it for you.

Note: The kiosk is an additional module that you can purchase from ChiroWrite to allow patients to check in and enter subjective information, if you choose.

2. When patients scan their ID card at a workstation, if this is configured, you can choose to open that patient's travel card or their

## 3.2.23.1.11 Miscellaneous

The configuration that takes place under the Misc. tab is as follows:

System Settings	-9-
Global   Global 2   Global 3 Save Enable Automatic I Automatic Logoff	Global 4   SOAP   SOAP 2   Printing   Scanning   Copy Options   Patient Check In     Logoff (Any information not saved when the automatic logoff is initiated will be lost)     Seconds: 99999
Mai Mai	
Email Server	mail softworksolutions.com
Send User Name:	ksisneros@softwonsolutions.com
Send Password:	
Port	26
SSL Option.	© Nore © Implicit © Explicit ⊠ Authenticate
Receive User Name	
Receive Password	
Tax Rate:	
Picture Default Pen Setting	<b>3</b> 5
Pen Width:	80.00
Color Code:	Red

1. Enable automatic logoff will set ChiroWrite to automatically log off and close after the program has been idle for a certain amount of time. Certified users will find that this is automatically set for you if you are completing the meaningful use program.

2. Mail settings allow the setup of the doctor's or office email so that notes can be directly emailed to another provider, insurance or other legal entity.

3. Tax rate can be set here for those who are using the ChiroWrite Scheduler. This is a separate module is mostly used by doctors who have cash practices since ChiroWrite does not do billing.

4. Default Pen Settings allow the user to choose a default color that is used to draw on images throughout the system. The most widely recognized image being found on the travel card. The normal default color is blue, but now it can be any color you choose.

### 3.2.23.2 Security Configuration Options

Security Configuration allows for the creation of new system users and the ability to edit existing users in the system. Each user of the ChiroWrite system should have his or her own login.

#### 3.2.23.2.1 Create a New System User

- 1. Select Administration > System Configuration > Security.
- 2. Enter the User's name.
- 3. Select the security features for the user by clicking the appropriate check boxes. This gives certain users in the system different

privileges and capabilities.



- 4. When you are finished, click Save.
- 5. Select the Close button.

## 3.2.23.2.2 Edit an Existing System User

- 1. Select Administration > System Configuration > Security.
- 2. Highlight the user and click the Edit button.
- 3. Make the necessary changes and click Save.
- 4. Click Close.

## 3.2.23.3 Import/Export Configuration

ChiroWrite allows the ability to import or export data from the Solution Providers shown below.

🛃 Import/Eq	port Settings
	Eclipse PMP   InPhase   MediSoft   Chiro8000   EzBis   Generic   Misc.
Save Close	Eclipse       PMP       InPhase       MediSoft       Chiro8000       EzBis       Generic       Misc.         Eclipse Settings       Enable Eclipse Integration       Automatically listen for new Eclipse patients       Single Client Performs Charges?         Path Location:

## 3.2.23.4 Kiosk Settings

Information regarding the ChiroWrite Kiosk Settings can be found in the Kiosk Manual. This can be accessed through ChiroWrite by navigating to **Help > Kiosk Online Help**. You can also contact the ChiroWrite technical support team at 1-800-642-6082 for additional information and instruction.

## 3.2.24 Predefined Plans

In ChiroWrite, you now have the ability to create patient treatment plans based on the types of treatments you provide your patients over a period of time. It allows you to create and use a treatment plan to quickly select the treatments your patient will undergo over that period of time and allows you to make changes to the plan as necessary.

### 3.2.24.1 Creating a New Plan

- 1. Select Administration > Treatment Configuration > Plans.
- 2. Click **New** to begin creating a new treatment plan.
- 3. Enter in a **Description** for the plan to give yourself an idea of what that plan may be for.
- 4. Select Treatments over the next period of time as you normally would.



- 5. When finished select Save.
- 6. Click Close.

- 1. Select Administration > Treatment Configuration > Plans.
- 2. Click Edit to begin editing an existing treatment plan.
- 3. Edit the information that you would like.



- 4. When finished select Save.
- 5. Click Close.

### 3.2.23.3 Using a Predefined Plan

To use a predefined treatment plan that has already been created, begin in an **exam note** or a **SOAP note** for the patient you are working with.

- 1. Select the Plan screen and select Change Plan to activate the screen.
- 2. Select one of the predefined plans that have been created.
- 3. Select Add Treatment and all of the treatments associated with the predefined plan will be added to the patient's plan.

Standard Template •	Plan					233	1 4	Visit: 6/15/2010
Sacrollac Test Orto Shooler Tests Orto Shooler Tests Orto Elbor Tests Orto Elbor Tests Orto Wint Tests Fost Tests Fost Tests UE Macch Testing Cenical Spire Pulse Dagnosic Faquets Page Dagnosic Requests Reser Of Systems 78ay Finding Today's Insatrients Proposis Narstive Ending Exan Outsim 1 Exan Outsim 1 Exan Outsim 1 Exan Outsim 1 Exan Cestem 2 Pictures Body Picture 61 My Picture 81 My Picture 85 My Picture 85 My Picture 85	Gool Proceed w Category Treatment Precision Count Frequency: Time Duration: Diagnosis to Purpose of to A	s/Commer with Thecap Adjustr Adjustr Adjustr Adjustr Adjustr Hour 1 Smin 1 Smin 1 Smin 1 Smin 1 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 S Smin 2 S Smin 2 S Smin 2 S Smin 2 S Smin 2 S Smin 2 S Smin 2 S Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 Smin 2 S Smin S Smi Smin 2 Smin 2 Smin 2 Smin 3 Smi	nts   ees as dir ments ( 2x Day 20min 20min 20min 20min 20min	Adjunction Adjunction 3x Week 30min 3 Week	Change     Change	Plan y Rehab ategory redefined Pic djunctive The Six 60min 5 Remove Tree	All	Selected Treatments: hot packs on a PRN basis for 15 minute Massage 2x por week duration of 4 weeks Spinal Manipulation 2x por week duration of 4 weeks to decrease, pain and swell Therapeutic Exercises on a PRN basis to improve strength, flexibil

- 4. Enter any additional treatments that you would like your patient to have in their personal plan.
- 5. Enter any additional information that your patient needs in their exam or SOAP note.
- 6. Click the Exit Workflow button to save all changes.

## 3.2.25 Exercise Log

The exercise log section will show you how to configure ChiroWrite to allow you to begin working with the exercise log found on Today's Treatments. Learn more by watching the Exercise/Activity Log video.

## 3.2.25.1 Creating Exercises

- 1. Administration > Treatment Configuration > Exercises.
- 2. Click on **New** to create an exercise.
- 3. Enter a **Description** of the exercise and select the **Units** in which the exercise is measured.

😔 Edit Existin	g Exercise		-9-	
Save	Description: Units: Status:	Bicep Curl bs kgs seconds grams		

4. Click Save and Close when you have finished.

- 1. Administration > Treatment Configuration > Exercises.
- 2. Select an exercise from the list that you want to edit and click the Edit button.
- 3. Click Save and Close when you have finished making changes.

😌 Edit Existin	ng Exercise		-2-	
Save	Description: Units: Status:	Bicep Curl bs kgs seconds grams		

## 3.2.25.3 Mapping Exercises

Once you have created exercises that you perform in your office, you need to map those exercises to certain body parts that will utilize them. If you do not have the body parts that you need please see section <u>2.4 Treatment Areas</u> to add them. If all of your body parts are present then continue on with the steps provided below.

- 1. Administration > Treatment Configuration > Exercises.
- 2. Click on the Protocol Areas button.

Exercises			-9-6
	Exercise	Units	Status
<b>X</b>	Bicep Curl	lbs	Active
Close	Dead Lift	lbs	Active
	Leg Lift	lbs	Active
	Tricep Extensions	lbs	Active
New			
Edt			
_			
rotocol			
Areas			

3. Now select an area where you would like to map exercises to and click to Mapping button.

	Enable Up & Down arrows for sequen	cing	
	Area	Protocols Assigned?	Ŀ
Close	Leg	Y	
	Neck	Y	
	Shoulder	Y	
	Triceps	Y	14
$\triangle$	Cervical	N	
Up	C0	N	
-	C1	N	
	C2	N	
Down	C3	N	
	C4	N	
	C5	N	
	C6	N	
Mapping	C7	N	
	Thoracic	N	
	T1	N	
	T2	N	
	79	M	

4. Using the green arrows select the exercises you would like to add to that body part.

	24.F '			
🛃 Mapping				-9
X	Area: Leg			
Close	Selected Types		Available Types	
	Description		Description	
	Dead Lift		Bicep Curl	
	Leg Lift		Tricep Extensions	
		~		
		4		
Down				
Up Down		•	Tricep Extensions	

5. Click **Close** when finished. There is no need to exit ChiroWrite for changes to be seen.

# 3.2.25.4 Entering Exercises

Once the configuration has taken place for the exercises, you can begin utilizing the exercise log for your patients. Remember this information will copy from visit to visit.

#### 1. Today's Treatments > Log Tab.

2. Click the Add button to begin making selections.

ChiroWrite File Administration Office Activitie	es Patient Activities Cur	ent Patients	Help	-	_		-	_		- 0 - ×-
🎤 🗊 🚛 🗳	s 🔫 🦯 T	Pat Tot	ient Bruce Wayne al Visits: 93 Last Visit 2/8/2011	1			w	hat's I	New	2 🚫 😭
SOAP •	Today's Trea	tments		۷	1		•	2/8/2	011	- 📦 🧭
SOAP     Subjective	Treatment Notes	Log My	Notes							
- Objective - Assessment	Add	Remov	e Duration: 15 Min	s	lart Tin	ne: 43	30 P1	4	End 1	lime: 4:45 PM
Today's Treatments	Rody Part	1100	Protocol	Se	et 1	Se	t 2	Se	t 3	
- Charges Diagnosis	Body Fait	LIND	FIOLOCOI	Rep	#	Rep	#	Rep	#	
- SOAP Custom	Triceps	Both	Tricep Extensions	1	10	2	10			12 lbs
- SOAP Custom 2 - SOAP Custom 3	Shoulder	Right	Bicep Curl	1	10	2	10			
Pictures	Neck	•								
SOAP Custom 3 Pictures Body Picture Cervical Spine Picture Whole Spine Picture	Neck Shoulder Leg Triceps									

- 3. Select from the drop down boxes in each section to begin creating an exercise log for the specific patient you are working with.
- 4. Type any additional comments in the comment box at the end of each exercise or use the comment box at the bottom.
- 5. You can also add the duration and start and stop time for the exercises completed.

6. Click the **Treatment tab** to return to the treatment screen or click on the next item in your worxflow. The information will be automatically saved.

## 3.2.26 Login Audits

ChiroWrite keeps a log of who logs into the system and the date and time.

1. Select Administration > Audits > View Logon Audits.

Login Aud	Sets .	1.8				
	Name	Login Time	1			
X	Softworx Solutions	10/12/2007 5:40:13 PM				
Close	Softworx Solutions	10/12/2007 5:48:50 PM				
	Softworx Solutions	2/9/2010 12:28:22 PM				
	Softworx Solutions	2/9/2010 12:29:56 PM				
New	Softworx Solutions	2/9/2010 12:31:39 PM	1			
	Softworx Solutions	2/9/2010 12:38:21 PM				
_	Softworx Solutions	2/9/2010 12:38:41 PM				
64	Softworx Solutions	2/11/2010 12:00:32 PM				
EGE	Softworx Solutions	2/11/2010 3:27:11 PM				
	Softworx Solutions	2/11/2010 3:41:18 PM				
	Softworx Solutions	2/15/2010 9:59:55 AM				
	Softwork Solutions	2/15/2010 10:22:33 AM				
	Softworx Solutions	2/15/2010 10:52:25 AM	-			
			*			

2. Select Close when finished viewing.

Note: The New and Edit buttons do not do anything on this screen.

## 3.3 Office Activities

Office Activities assists with checking patients in and out, a comprehensive list of the patients that received care during a specified time frame, the ability to configure and run reports not pertaining to a specific patient, and the ability to view what changes were made and when they were made.

## 3.3.1 Check In A Patient

#### 1. Select Office Activities > Check In/Out.

🖷 Check In/O	ut			7 💌
	Last Name	First Name	Check In Time	
	Little	Missy	9:08 PM	
Close				
In				
Out				

- 2. Click the In button to launch the search screen.
- 3. Search and highlight the patient you want to check in.
- 4. Click the Select button.
- 5. You now can see that the patient is listed as checked in for today. Click Close.

## 3.3.2 Check Out a Patient

- 1. Select Office Activities > Check In/Out.
- 2. Highlight the patient you want to check out.

🖳 Check In/Ou	ut			? ×
	Last Name	First Name	Check In Time	
	Combs	Tina	8:03 AM	
Close	Flintstone	Fred	8:01 AM	
	Little	Missy	9:08 PM	
Out				

#### 3. Click the **Out** button.

4. Select Close.

## 3.3.3 Show Daily Visit

1. Select Office Activities > Show Daily Visits.

2. Choose the date or date range for your Daily Visit list using the Calendar buttons.

3. Click the Charges check box and/or Diagnosis check box to include in the report, if desired.

4. Click **Search** and a list of patients for the dates specified will appear. Notice in the visit type area there are numbers in parentheses that reflect the unit amount for each CPT code. Learn more about the unit charges by watching the <u>Report Unit</u> Charges video.

💀 Show Visits							0	
	Search Criteria							
X	From Date:	5/23/2012	8-	To Date:	5/30/2012	0-		
Close	Include:	Charges	🗹 D	iagnosis				
	Sort By:	Name	O D	ate	E	Exported	Charges	
2	No. Date	Last Name		First Name		V	/isit Type	Ŀ
Search Make Active	5/23/2012	Flintstone		Pebbles		S 9 9 9	Scheduled Visit 8941(1) - Manipulation/3 to 4 Regio 7010(1) - Thermotherapy/Packs 7014(1) - EMS/Interferential	×
	2 5/23/2012	Flintstone		Pebbles		5 9 9	Cheduled Visit 17012(1) - Mechanical Traction 17010(1) - Thermotherapy/Packs	
Print List	3	Griffin		Chris		S 9 9 9 7 7 8	Scheduled Visit 8940(1) - Manipulation/1 to 2 Regio 7010(1) - Thermotherapy/Packs 7014(1) - EMS/Interferential 22.1 - Lumbar Disc Bulging 39.3 - Lumbar Subluxation 47.2 - Lumbar Sprain	
	5/24/2012	Lynch		Jane		E 7 7	ixam 122.1 - Lumbar Disc Bulging 139.3 - Lumbar Subluxation	

5. In order to make a patient active, highlight the name of the patient and click the **Make Active** button. This will take you to the patients travel card.

6. Copy List will allow you to copy the information and paste it into another program.

- 7. Print List will run a report that can be printed.
- 6. When you are finished, select Close.

#### 3.3.4 Reports

The reports menu provides reporting options that are not patient specific. Here you will find ChiroWrite's patient intake forms and reports that can be generated for the entire practice. For example, the Welcome to the Practice Letter is designed to work from the date range specified and produce a welcome letter for all patients that were added during that range. The intake forms can be printed and given to patients to collect information from them while they are in the waiting room.

- SOAP Notes Paragraph Style
- SOAP Notes Detail
- Welcome to the Practice Letter
- Referral Letter
- General Marketing Letter
- Daily Living Assessment Form Patient Intake Form
- Vehicle Accident Information Form Patient Intake Form
- Medical History Form Patient Intake Form
- Patient Complaints Form Short Patient Intake Form
- Patient Complaints Form Detailed Patient Intake Form
- Oswestry Low Back Index Patient Intake Form
- Neck Disability Index Patient Intake Form
- Roland-Morris Questionnaire Patient Intake Form
- Provider Exam Form For the Provider

The Provider Exam Form will assist the doctor in taking notes that match screens in ChiroWrite to assist them in getting used to the ChiroWrite system.

## 3.3.4.1 Run Reports

1. Select Office Activities > Reports.

Reporting							-0-0
-	Report Filters						
X	From Date:	6/25/2012	<b>B</b> •	To Date:	6/25/2012	0-	
Close	Office:						+
	Provider:						
Run	Case Type:						
TYGHT	External Type	22					
View	Constant () po.						
Prior	[a						
isport	Reports	ORV.					
	SOAP Notes - U	OP1					_
	SOAP Notes - P	aragraph Style					
	Accidents	anagraphicidie					
	X-Ray Findings						
Report	Welcome To The	e Practice Letter					
Config	Referral Letter						
	General Marketin	ig Letter					
	Daily Living Asse	ssment Form					
	Vehicle Accident	Information For	m				
	Medical History F	Form					
	Patient Complain	its Form - short					
	Patient Complain	its Form - Detail	ed				

Tip: Selecting SOAP notes for a date range here will give you SOAP notes for all patients found within that date range. For SOAP notes for one patient, select that patient and click the Patient Reporting icon.

2. Choose the To and From Dates for the Report.

3. Depending on which report is chosen you may need to select the Office, Provider, Case Type, and/or External Type from the drop down menu.

- 4. Select the Report.
- 5. Click the Run button and your report will display in Microsoft Word or Wordpad.
- 6. Click Close when finished running reports.

## 3.3.4.2 View Prior Reports

- 1. Choose Office Activities > Reports.
- 2. Select View Prior Report.
- 3. A listing of prior reports that were generated will appear. You can then select to View, Mark the report as sent, or print the report.
- 4. Click Close.

# 3.3.6 Patient File Audits

ChiroWrite gives you the ability to view any changes that have been made to any patient file at any time. Learn more by watching the Audit Log video.

1. Select a **patient** by either searching for them by clicking on the patients.

2. Select Office Activities > Audits.



magnifying glass button or picking them up from current

74507231076						-
Search Criteria						
Current Screen	<ul> <li>All Screens</li> </ul>	Other		-		
🔲 Use Case/Visit	Case		- Vis	sit		
Use Date Range	From Date:	2/17/2010	To Date: 2/17/2010	Q+		
Use Employee	Employee	ponnen co	•			
Date	Field/Action	Defore.	Atter		Performed By	_
2/17/2010 3:48 PM	Add Today's Treatment		Shoulder - Right Electrical Stimulation 80-120 freg @ 25volts		Solutions, Softwork	
2/17/2010 3:48 PM	Add Today's Treatment		Shoulder - Right hot packs 15 minutes		Solutions, Softwark	
2/17/2010 3:48 PM	Remove Today's Treatment	Shoulder - Right hot packs			Solutione, Softwork	
2/17/2010 3:48 PM	Add Today's Treatment		Shoulder - Right hot packs		Solutions, Softwork	
2/17/2010 3:48 PM	Add Today's Treatment		L4 - Spinal Manipulation		Solutions, Softwork	
2/17/2010 3:48 PM	Add Today's Treatment		L3 - Spinal Manipulation		Solutions, Softwork	
2/17/2010 3:48 PM	Add Today's Treatment		L2 - Spinal Manipulation		Solutions, Softwork	
2/17/2010 3:48 PM	Add Today's Treatment		T8 - Spinal Manipulation		Solutions, Softwork	
2/17/2010 3:48 PM	Add Today's Treatment		T6 - Spinal Manipulation		Solutions, Softwork	
2/17/2010 3:48 PM	Add Today's Treatment		T4 - Spinal Manipulation		Solutions, Softwork	
2/17/2010 3:48 PM	Physical Exam Treatment Tolerated		Mild Pain		Solutions, Soltwork	
2/17/2010 3 48 PM	Plan Action	Change Plan	Proceed with Theoanier	a as directed	Solutions Soltwork	

All audits will be shown when this screen pops up. The number of audits can be filtered or limited by making selections above.

4. Selecting **Current Screen** will show changes made to the previous screen you were on. Selecting **All Screens** will show all changes made to the file. Selecting **Other** will allow you to choose specific sections of the system to view changes.

- 5. Checking Use Case/Visit will allow you to select a specific case or visit that you want to see what changes were made.
- 6. Checking Use Date Range will allow you to select a range of dates where changes may exist.
- 7. Checking **Use Employee** will allow you to see if a specific employee made any changes to the patients file.
- 8. Select the Get Audits button after making your selections to refresh the list.
- 9. Click on Close when finished.

## 3.3.7 Print Signatures

A report can be generated that contains all the signatures for a all patients who have come into the office and signed in for a given time period.

- 1. Click on Office Activities > Print Signatures.
- 3. Choose the office and the date range for which the report should be run. Then click the Run button.

Close	Select the Offic Then click the "F	e and the Date Range from which you would like to run the p RUN" button.	atient lis
01030	Office Name:	•	
	1	Greg House Chiropractic	

The report that gets generated looks like the one seen below.

Printed Date: 5/14/2012

#### Softworx D630

370 CenterPointe Cir Altamonte Springs, FL 32701 800.642.6082

Signature History From: 5/12/2012 To:5/21/2012

Patient	Date
Wayne, Bruce	5/14/2012 10:56:00 AM
Duck, Donald	5/14/2012 1:01:00 PM
Smith, John	5/14/2012 1:02:00 PM
Flintstone, Pebbles	5/14/2012 1:03:00 PM

Signature Buce Wayn Dante Dup Odu Smith Pebbles Flittstone

## 3.3.8 Print Checked-In History

A report can be generated that contains all the patients who have been checked-In either using the patient check-in module or the scheduler module come into the office and signed in for a given time period.

1. Select Office Activities > Checked-In History.

2. Choose the office and the date range for which the report should be run. Then click the Run button.

X	Select the Off Then click the	ice and ti "RUN" bi	he Date Range utton.	from whic	ch you w	ould like to run	the patient lis
Close	Office Name:					•	
Run	Date Range:						
		From:	5/21/2012		To	5/21/2012	

The report that gets generated looks like the one we see below.

#### Softworx D630

370 CenterPointe Cir Altamonte Springs, FL 32701 800.642.6082

Log-In Summary From: 5/10/2012 To:5/14/2012

Patient Wayne, Bruce Cho, Margaret Wayne, Bruce Check-In Time 5/11/2012 4:29:00 PM 5/11/2012 4:29:00 PM 5/14/2012 4:20:00 PM Check-Out Time

5/14/2012 10:56:00 AM 5/11/2012 4:29:00 PM 5/14/2012 4:21:00 PM

## 3.4 Patient Activities

Patient Activities assists with various things relating directly to the patient. Here we can input patient allergies, patient medications, and get education pieces that can be given to the patient. Mass maintenance can be completed to a patient's file to add diagnostic codes or complaints to several visits at once. A patient's diagnostic history can be viewed and orders can be created for x-rays, an MRI or a laboratory test.

### 3.4.1 Patient Allergies

In ChiroWrite, you can input allergies that patient's may have to certain medications. If you are using the certified version of ChiroWrite please refer to the meaningful use manual for assistance.

#### 1. Navigate to Patient Activities > Patient Allergies.

nedication allergies

2. Click the **New** button to enter in a new allergy. You can select from allergic reactions you may have already entered in from the drop down or enter one in on the spot. Also be sure to type in the medication they are allergic to and the date. Could be the date entered, if they are unsure of the date they knew about the allergy.
| × | - ? - <del>- ×</del> |                             | Medication Allergy                               | - Add New |
|---|----------------------|-----------------------------|--------------------------------------------------|-----------|
|   |                      |                             | Medication:                                      | Ш         |
| • | •                    |                             | Reaction:                                        | Save      |
|   | <b>•</b>             | day , November 04, 2011     | Date:                                            |           |
|   |                      | -                           | Status:                                          | X         |
|   |                      | alue                        | InActive as of:                                  | Close     |
| • | •                    | day , November 04, 2011<br> | Reaction:<br>Date:<br>Status:<br>InActive as of: | Save      |

3. Click **Save** and **Close**, when finished.

### 3.4.2 Patient Medications

In ChiroWrite, you can now input the medications your patient may be taking two different ways. You can input medications patients may be taking ahead of time or while in the patient's file. If you are using the certified version of ChiroWrite please refer to the meaningful use manual for assistance.

#### Ahead of Time

- 1. Administration > Medications.
- 2. Click New to enter in a new medication.
- 3. Enter in the **Medication Information** as shown below.

Name, Dose, Form, Route, Frequency, Status and generic drug name if needed.

4. Select **Save** and **Close**, when finished.

n						
Medication		Dose	Form	Route	Frequency	Status
Claratin		10 mg	Tablet	Oral	1 per day	Active
Prilosec - (O	meprozole)	20 mg	Tablet	Oral	1 per day	Active
Zyrtec		10 mg	Tablet	Oral	1 per day	Active
Add New N	ledication					9 33
	Medication Bra	nd Name:	Metformin			
	Dose:		500 mg			
Save	Form:		Tablet			
X	Route:		Oral			
Close	Frequency:		1 per day			
	Status:		Active •			
	RxNorm Code					
	Generic Drug N	lame:	Glucophage			

#### While in the patient's file

- 1. Open a patient's file to work with by using the magnifying glass
- or by selecting someone from current patients.
- 2. From the topmost menu, select Patient Activities > Patient Mediations.
- 3. Click New to put in a new medication for the patient you are working with.

Medication name)	Brand Name (generic	Dose	Form	Route	Frequency	Date Started	Date Stopped		
Add New	Medication								-0
	Medication:					ine Preside			
	Advil				Medica	oon Details	-		
Save	Claratin				Dose.		200 mg		
	Philosec				Form:		Tablet		
X	Zyrtec				Route:		Oral		
Close					Freque	ncy:	Every 4-6 hours fr	or pain	
					Status		Anthen		
					Children .		ACOVE		
					Date St	arted.	🗷 Thursday ,	July	15, 201
					Date St	opped:	C No Value		
					RxNorr	n Code:	1		
					0.40	and Manual	Automatical.		

4. Now you can either select a medication from the list or enter it in right here.

5. Be sure to include the **date when they started the medication** and if no longer taking it change the **status to inactive** and **change the stopped date**.

- 6. Select Save.
- 7. Click Close.

## 3.4.3 Education

In ChiroWrite, patient education resources can be brought up by selecting a patient and navigating to **Patient Activities > Education**.

Education		-9-
	Description	Date Given
Close	Medline Plus ICD: 739.3 - Lumbar Subluxation	5/11/2011
	Medline Plus ICD: 739.3 - Lumbar Subluxation	5/11/2011
New	Medline Plus ICD: 739.3 - Lumbar Subluxation	5/11/2011
Launch Medline Plus Connect		
Remove		

Now, depending on how you have setup your system you may choose to click the **New** button, if you already have resources you already like to give to patients. If this is the case, you will have static (resource is housed on a computer in your office) or dynamic (web based) resources for medications and laboratory results as well. Otherwise, most doctors are going to choose the **Medline Plus Connect** button and choose a diagnosis for which they would like information for.



Clicking the save button after selecting a diagnosis will pop up an internet browser to Medline with information regarding that diagnosis. This can then be printed and given to the patient.

#### 3.4.4 Mass Maintenance

Mass Maintenance is our way of easily allowing doctors to add diagnosis codes or complaints to several visits at once. In the diagnosis section, you are allowed to add from the list of diagnosis codes as well as copy codes from other visits. In the complaints section, you are allowed to copy complaints from one visit to another. Learn more by watching the Mass Maintenance video.

#### Diagnosis

1. Patient Activities > Mass Maintenance > Diagnostic Codes.



2. Choose if you want to copy codes from another visit or from the general list where available codes are shown.

To view codes that are part of an already created visit, **select** the visit from the **drop down box** near the top of the screen. To view codes that are just part of the system see the list of available codes. Here you can search by selecting part of an ICD code, part of a keyword or by using your categories just as you would on the diagnosis screen. 3. Click Close when finished.

#### Complaints

1. Patient Activities > Mass Maintenance > Complaints.



2. **Choose** the visit you want to copy complaints from, then choose the visit or visits you want to copy the complaints to an click the **Add** button. From here, you are also able to add information to a complaint including how it's doing, the pain level, the severity and the frequency. You can also remove complaints if needed using the same method.

Note: You cannot add any complaints that have not already been created in a visit here. This means they have to at least exist in one visit for them to be copied.

3. Click **Close** when finished.

#### 3.4.5 Diagnosis History

Should you want to know about the patient's diagnosis history click on **Patient Activities > Diagnosis History** and you can view diagnosis codes that were used in the past for this particular patient. You can view diagnoses that have been resolved, entered by mistake or were made inactive. Learn more about this by watching the Diagnosis History video.

Code	Description	Created On	Removed On	Status
346	Migraine	11/3/2010		
310.2	Post Concussion Syndrom	11/3/2010		
739.3	Lumbar Subluxation	5/21/2010		
842	Strain, Sprain of the Wrist	5/21/2010	5/31/2011	Resolve

### 3.4.6 Orders

The Orders section allows you to create specific tests that you might normally request so that they can be selected for any given patient. This is configured by navigating to **Administration > Order Settings > Orders**.

P Add New	Order				- ? - <mark>- × -</mark>
8	Туре:	O XRay	OMRI	🔿 Lab	
Save	Description:				
X		🔄 Test resul	ts are Positive/Nega	tive or numerical in fo	ormat
Close	Status:	Active	<b></b>		

Select the type of order you are entering, a description for that order and also be sure to check if the test results are positive/negative or in numerical format. This check is especially important for meaningful use. The orders as they are entered will show up in the section much like the image shown below. Learn more about using the orders section by watching the <u>Diagnostic</u> <u>Orders</u> video.

Orders				6
	Order	Туре	Status	^
X	Complete Blood Count w/Differential (CBC)	Lab	Active	
Close	Creatinine	Lab	Active	
	Fasting Blood Glucose	Lab	Active	
	High-sensitivity C-reactive protein (HS-CRP)	Lab	Active	
New	Thyroid Stimulating Hormone (TSH)	Lab	Active	=
	Triglycerides	Lab	Active	
	Neck	MRI	Active	
E-fit	Shoulder	MRI	Active	
Cuit	With Contrast	MRI	Active	
	Without Contrast	MRI	Active	
	AP Hip	XRay	Active	
	AP Pelvis	XRay	Active	
	Bilateral Hip	XRay	Active	
	Cenvical	XRav	Active	-

## 3.4.6.1 Order Options

The Order Options section allows you to create specific instructions that might normally be included in an order that can be used for any patient. This is configured by navigating to Administration > Order Settings > Order Options.

Р	Туре:	🔿 XRay	O MRI	🔿 Lab	O All	
Save	Description:					
Х	Status:	Active	•			

Select the type of instructions you are entering, the actual instructions and select it as active. The instructions could potentially be used for all types, if needed. The instructions as they are entered will show up in the section much like the image shown below.

🖳 Order Opt	ions		- ? - 🛋
X	Description	Туре	Status
	Routine	All	Active
Close	AM Test	Lab	Active
	Every other day times 3	Lab	Active
	Fasting	Lab	Active
New	PM Test	Lab	Active
Edit			
	L		

#### 3.4.6.2 Order Indications

The Order Indications section allows you to create specific indications that might be revealed by a specific test again these can be included in an order that can be used for any patient. This is configured by navigating to Administration > Order Settings > Order Indications.



Select the type of indication you are entering, the actual indication and select it as active. The indications could potentially be used for all types, if needed. The instructions as they are entered will show up in the section much like the image shown below.

😔 Order Indica	tions		7
	Description	Туре	Status
X	Neck Pain	MRI	Active
Close	Shoulder Pain	MRI	Active
	Back Pain	XRay	Active
	Hip Pain	XRay	Active
New	Osteoporosis	XRay	Active
	Pneumonia	XRay	Active
Edit			
Lon			

#### 3.5 Current Patients

Current Patients allows you to see which patients are checked into the office and ready to be seen. As patients are checked out, they will be removed from this list. This is where you can also view a list of patients that may have incomplete notes. More information can be found by watching the <u>Current Patients Video</u>.

1. Select the show Patients With Incomplete Notes button.

ee CurrentPat	ients				0 ×
X	Show Ch	ecked In Patients	Show Patients With In	complete Notes	
Close	Sort By: • V	/isit Time 💿 Patient Name	O Provider	Provider:	
	Visit Date	Patient Name	Provider	Visit Reason	ĥ
	5/24/2011	Chris Griffin	Softworx Solution	Initial Exam	
Select Patient	5/24/2011	Meg Griffin	Softworx Solution	Initial Exam	1
	5/24/2011	BamBam Rubble	Softworx Solution	Scheduled Visit	
Go To Note	6/1/2011	Paula Deen	Softworx Solution	Scheduled Visit	
	8/10/2011	Paula Deen	Softworx Solution	Scheduled Visit	
Remove	9/7/2011	Paula Deen	Softworx Solution	Scheduled Visit	
	9/8/2011	Paula Deen	Softworx Solution	Scheduled Visit	
	10/14/2011	Paula Deen	Softworx Solution	Scheduled Visit	
	10/04/0011	Daula Daon	Coffmany Calutio	Cohodulad Visit	4

- 2. Select the **Patient** for which you would like to complete notes for.
- 3. Click Select Patient to simply just select the patient or Go To Note to go to the note for that specific date of service.
- 4. Click **Close**, when finished.

## 3.5.1 Patient Travel Card

The Patient Travel Card consists of five areas: Summary 1, Summary 2, History, Trends and Notes. The Summary window will provide a snap shot overview of the patients information.

Patient To	aval Card							1 H
	Summary 1	Summar	y 2 History Tree	nds Notes		Cases:	Unknown, Last 3/23/2011, First 5/21/2010	
Close	Expand	Last Exa Visits Se	-3 Q	Visits: 14		7 4	2	
Visit		L	1/4	LANGIL	Sublux	ations	Chief Complaint(s)	
Dates			- LU	(1/-	Area	Notes	Details	2
			R	Ŵ	C2 C4		1. Left Shoulder Seventy: Mild to Moderate, Pain Level: 3	
SOAP			~~		12		2 Louise Back	
Loday					15		Severity: Mild to Moderate, Pain Level: 3	
114400					TR			
Exam	Last Visit T	reatmen	nts		1.8		3. Bilateral Posterior Neck	
Today	Area	L/R/B	Treatment					
	C2	Let	Spinal Adjustme	ent				
	C4	Right	Spinal Adjustme	ent				
	12	Bilatera	Ih Spinal Adjustme	ent				
	15	Bilatera	Ily Spinal Adjustme	ent				
	Lower Back		hot packs		Diagno	sis		
	Neck		Ultrasound		739.3	14 - 5/21/2010	Lumbar Subluxation	
	Shoulder	Right	Electrical Stimu Electrical Stimu	ulation	842	14 - 5/21/2010	Strain, Sprain of the Wrist	
	Treatments	Tolerated	With: Mild Pain					, •

## 3.5.1.1 Summary 1 Tab

The Summary 1 tab allows you to add information on the patients visits, SOAP, and regular exams. The Summary screen will allow you to expand the body images, review patient images, read patient complaints, treatment and diagnosis information.



The Summary window will also display subluxations and your My Notes section of the Today's Treatment Screen if you setup your configuration that way.

- 1. Select the patient.
- 2. Choose the Summary 1 tab on the travel card, if it hasn't been chosen already.
- 3. Select the Visit Dates button and a calendar will appear highlighting in bold the dates that the patient has visited the office.



4. Click Close.

## 3.5.1.1.2 SOAP Today

If the system is being used in a real time mode, or the SOAP note you wish to enter is for a current date, then you may use the **SOAP Today** button. The system will take you into the SOAP Worxflow.

- 1. Select the patient.
- 2. Choose the Summary 1 tab on the travel card, if it hasn't been chosen already.
- 3. Click the SOAP Today button and the Subjective window appears with the following icons:



## 3.5.1.1.3 Exam Today

If the system is being used in a real time mode, or the EXAM you wish to enter is for the current date, then you may use the **EXAM Today** button. The system will take you into the Exam Worxflow.

- 1. Select the patient.
- 2. Choose the Summary 1 tab on the travel card, if it hasn't been chosen already.
- 3. Click the **Exam** button to access the Complaint window in the Exam Worxflow.
- 4. Select the Complaint Assist button to step through the questionnaires.

Standard Template	Compla	inte	A S S S S S S S S S S S S S S S S S S S	-	65
Patient Complaints     Complaints     Daily Living Assesmen     Self CareHygiene     Communication     Normal Living - Sitting =	Compia	Opening Com	nments:		
Normal Living - Stand     Normal Living - Lifting     Ambulation     Travel     Non Specialized Hanc     Sexual Function	Complaint	Area 1. Right Shoulder	Details Severity: Mild, Pain Level: 1 Comments: COMPLAINT - Right Shoulder is slightly better.		
Sieep     Social "Recreational #     The Effects Of Medic:     Pain Intensity     Pain Frequency		2. Right Hip	Comments: Right Hip is slightly worse.		
Examination     Vital Signs     Mensuration Circumfe     Posture Station Obse     ROM Cervical     ROM Dorsal     ROM Lumbar     BOM Shoulder					
- ROM Elbow - ROM Knee - ROM Knee - ROM Wrist - ROM Hip - ROM Ankle/Foot - Neuro Reflexes - Neuro Cranial Nerves		Closing Com	ments:	î v	

Tip: Please enter information in the Opening and Closing section below in complete sentences.

5. Click the Exit Worxflow button when finished.

#### 3.5.1.2 Summary 2 Tab

Summary 2 provides the same options as Summary 1 with the Visit Dates, SOAP Today, and Exam Today buttons while also allowing you to view the patients medical history, x-ray notes, management plan, and accident description.

Patient S	ummary		
	Summary 1 Summary Patients Medical History	Cases: MVA, First Visit: 9	Patients Management Plan as
X	Medical History	Management Plan	prescribed by the
Close Visit Dates	Mr. White has recorded that his family doctor is Tom Jones. His ast visit date was 11/25/2006. The name of the patient's chiropractor is Jill Till. His last exam date was 11/1/2006. The patient denies any surgeries within the past five years. Mr. White states that he currently has allergies and high blood pressure. He reports a family history of arthritis and cancer.	BEST Tech 2x per week / duration of 3 cold packs 3x per day for 15 minutes / Electrical Stimulation 3x per week / duration of 3 to reduce muscle spasms a Neuro-muscular Re-educa 2x per week for 30 minutes	weeks duration of 2 weeks weeks and pain tion / duration of 4 weeks
SOAP Today	Evaluation of X- Ray	Accident Description	Full description of the accident the patient was in.
Exam Today	Cervical The following views were taken: A-P Lower Cervical, lateral cervical, flexion and extension. In general there were no fractures, dislocations or osseous blastic/lytic lesions. Cervical listing is considered normal. Spinous processes are noted to be largely midline. The cervical lordosis is within normal limits.	Mr. White advised that he was accident on 1/5/2007 in which that he was being driven in a fu row on the right side while the approximately 20 mph when th occurred during the early morr dry and visibility was good. M by a mid-size car. The patien vehicle involved in the acciden car. The vehicle Mr. White or collision. The patient further s the accident. He stated that hi	involved in a motor vehicle he was a passenger. He stated ill-size car and seated in the rear vehicle was traveling at a speed of the accident occurred. The accident ing hours, road conditions were r. White stated he was rear ended t also mentioned there was another t. The other vehicle was a full-size occupied was involved in a frontal stated that he was not prepared for is head moved from left to right

# 3.5.1.3 History

**History** provides access to the patient's subjective notes and treatments performed for the block of time selected allowing the doctor to see treatments they have been performing over a period of time and the patient's responses to the treatments.

From: Thu	rsday, March 13, 201 - To:	Saturday ,	April 12, 20	Show All     Refresh
Visit Date	Subjective	Treatmen	ts Performed	Click the her
4/12/2008	1. Right Shoulder: Same, 8     2. Headaches: Better, 3     3. Right Posterior Neck: Si	C1 to C4 C6 ame, 5 C7 T2 T5 T9 Thoracic Treatment	Right Bilaterally s Tolerated With:	Spinal Mari Spinal Mani Spinal Mani Activator Activator Activator Electrical Stimulation 25 htz Mild Pain
4/9/2008	<ol> <li>Right Shoulder: Same, 8</li> <li>Headaches: Better, 3</li> <li>Right Posterior Neck: Si</li> </ol>	ame, 5 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	Right Bilaterally s Tolerated With:	Spinal Manipulation Spinal Manipulation Spinal Manipulation Activator Activator Activator Electrical Stimulation 25 htz Mild Pain
3/26/2008	1. Right Shoulder: Same, 8 2. Headaches:Better, 3 3. Right Posterior Neck: Si	C1 to C4 C6 ame, 5 C7 T2 T5 T9	Right Bilaterally	Spinal Manipulation Spinal Manipulation Spinal Manipulation Activator Activator Activator

## 3.5.1.4 Trends

Trends allows you to view the patient's progress under chiropractic care using graphical representations. The graphics are generated based on the subjective responses the patient has been giving over the date range specified. The graph can be generated for either Symptoms (Better/Same/Worse) or Pain Scale (1-10 ratings)



The Trends tab will also let you graph outcome assessment scores for the Owestry, Rowland Morris, Neck Disability Questionnaire and Pain Disability Questionnaire.

### 3.5.1.5 Notes

Then notes tab will allow you to view information from the My notes section of the Today's Treatment Screen as well as general notes in the system from click in on the pencil icon.

	Summary 1 Summary 2 History Trends	Cases: Unknown, Last 3/23/2011, First 5/21/2010
	Notes	My Notes
se	3/28/2011 Missed Appointment No Call No Show	11/4/2010 John has been working out quite a bit lately even though he is in pain. 5/21/2010 John's wrist still might have a slight fracture, however, x-rays were negative.
t 15		
ųр ay		
m ay		

### 3.6 Help

There are two ways you can access the ChiroWrite help area.

1. Select the button **F1** on your keyboard.

2. Select **Help > ChiroWrite Online Help**. Either way will take you to the help section where you can search any help topic you desire.

3. When finished, select the **red X** on the top right hand portion of the window that popped up and this will take you back into the ChiroWrite system.

ChiroWrite Online Help	F1
Kiosk Online Help	
License Information	
Update Configuration	
Check For Updates	
Join a Meeting	
Release Notes	
Lock System	F12
About	

#### 3.6.1 Kiosk Online Help

1. Select Help > Kiosk Online Help.

2. When finished, select the red X on the top right hand portion of the window that popped up and this will take you back into the

ChiroWrite system.

He	lp	
	ChiroWrite Online Help	F1
	Kiosk Online Help	
	License Information	
	Update Configuration	
	Check For Updates	
	Join a Meeting	
	Release Notes	
	Lock System	F12
	About	

## 3.6.2 Licensing Information

The licensing information can be accessed by clicking on

#### 1. Help > Licensing Information

This will show you the office information as well as the current status of your license.

🖳 Licensing	Ê.				9
Close			oft	worx tions	
Update License	Note: You will License" button obtain a new lic menu.	need to pr If this in ense Key	ovide the informa formation change This licensing v	ation below and is in the future window can be	d press the "Update , you will need to found under the Help
	Office Name:	Softwor	xD630		
	First Name:	Softwor	x		
	Last Name:	Solution	is		
	Address:	370 Cer	terPointe Cir		
		Suite 11	66		
	City:	Altamon	te Springs		
	State:	FL	ZIP	32701	
	Phone:	800.642	.6082		
	Email:	ksisner	os@softworxsolu	utions.com	(Not Required)
	Licence Status	Licence	Ok		

## 3.6.3 Update Configuration

The Configuration Editor is where you can find information about your server's name and whether or not the specific machine you are on is listening for updates from a billing system. It is also used by technical support to assist in troubleshooting your system.

#### 1. Help > Update Configuration.

Close	1. If this is a CLIEN put in this field can installed the Server	NT machine, then update the database server location. The value to be determined by running ChiroWrite on the machine where you r program and looking at the Licence Information under the Help
	Server	SOETWORYDE20 DO'SOETWORY
Update Config	Server.	SOFTWORKDOSPECSOFTWORK
	2. Only modify the	following line if instructed by your vendor. It should be blank normally
Viewer	Obtain Updates From:	
Viewer	Obtain Updates From: 3. If this machine is below to have this	s used to listen for updates from another system, select the system machine auto start the listening process.

### 3.6.4 Check for Updates

The Check for Updates option will allow ChiroWrite to check the Softworx Solutions website for any new updates that might be available.

1. Help > Check For Updates. But remember ChiroWrite does this for you automatically.

Note: Firewalls or anti-virus software may keep ChiroWrite from obtaining updates.

### 3.6.5 Join a Meeting

The Join a Meeting option will allow ChiroWrite to navigate to the GotoMeeting website, where a member of our technical staff can assist you with any issues you may be experiencing while using ChiroWrite.

1. Help > Join a Meeting.

Note: A member of our technical support staff will already need to be on the phone with you to use this feature.

#### 3.6.6 Release Notes

The Release Notes section just like our What's New? link will take you to the Softworx Solutions website for a look at our release notes. Here you can find valuable information about new features and how to configure them in your system.

### 3.6.7 Lock System

The ChiroWrite system is able to lock itself so that unauthorized users cannot access patient information. To lock the system click on

1. Help > Lock System OR Push the F12 button

To unlock the system, simultaneously push

#### 2. Control and F12

When the system is locked you will see the screen below and you will not be able to access anything in ChiroWrite. The system will need to be unlocked in order to regain access.



#### 3.6.8 About

The version of ChiroWrite that you are running can be accessed by clicking on

#### 1. Help > About

Below, you will see an example of what will show up when you make this selection.



### 4.0 System Icons

System icons allow you to search for patients, edit patient information, and add new patients to the ChiroWrite system. You are also able to view patient history, run reports for patients, add general notes for patients, and add patient pictures, x-rays or scanned documents. Finally, you can add patient alerts to notify you at certain intervals, send an instant message to another ChiroWrite user within your office and navigate to the home screen.

#### 4.1 Searching for Existing Patients



1. Click the

magnifying glass button and the search window below will display.

🖶 Patient				7 💌	
X	Search Criteria Last Name:			Sort By: @ Last Name	
Close	First Name:			⊘ First Name	
8	SSN:			Status:	
Search	Provider:		•		
	A B C				
	Matching Patients				
Select	Last Name	First Name	Address	SSN	
	J				

- 2. The system allows you to search using any one of the following criteria:
- Last Name
- First Name
- Social Security Number ( SSN)
- Provider
- Status

To search for the information, you can type the information into the search window box and click the **Search** button or click the lettered buttons to pull all records for that particular letter. You can also use the alphabetical letters to begin typing into the search fields above.

If you need to erase the contents of a search window you can click the Eraser button to delete what was typed in the field.

3. Once the patients name shows up under the Matching Patients window, highlight the patients name.

4. Click the **Select** button and the patients records will display. You will also notice, as shown below that the patients name, number of visits, and the date of his/her last visit is displayed on the toolbar.





### 4.2 Add New Patient Information



button.

Tip: The First and Last Name as well as the patients sex is required to add a patient record.

2. The new patient window will display with the following two windows. Fill in the information necessary and click Save.

Tip: Do not use this icon to add patients if you are linked with an external billing system.

3. Select Close.

### 4.3 Edit Patient Information



on the toolbar to edit a patients information.

#### Tip: Do not edit patient's information here if you are linked with a billing system.

- 2. The patient's record will appear on two pages. Make any necessary changes and click Save.
- 3. Choose Close.

1. Click the

## 4.4 Patient History



The patient history menu option allows you to search for existing cases the patient may have; you can create a new case for the patient and edit existing cases. It also allows you to search for visits the patient has already had and edit the visit while also allowing you to create new visits.

#### 4.4.1 Start a New Case

1. Search for the patient.



doctor's bag button to display the Patient History screen as shown below.

Patient H	istory							-9-	
	Cas	es .			Include InActive				
X	No.	Description		First Visit	Last Visit	No. Visits	Status	Kiosk	
Close	1	Personal Inju	ry	2/9/2010	5/21/2012	65	Active	Y	
Citose	2	Lower Back	<u>e</u>	2/11/2010	3/13/2012	206	Active		
New									
Case	Med								
	VISI	s <u>te</u>							
Edit	No.	Date	Reason						18
Case	206	3/13/2012	Scheduled Visit						. 8
	205	3/7/2012	Scheduled Visit						
	204	3/6/2012	Scheduled Visit						
New	203	3/5/2012	Scheduled Visit						
VIDE.	202	3/2/2012	Scheduled Visit						
	201	3/1/2012	Scheduled Visit						
Edit	200	2/29/2012	Scheduled Visit						
Visit	199	2/28/2012	Scheduled Visit						
	198	2/27/2012	Scheduled Visit						
	197	2/26/2012	Scheduled Visit						
New	196	2/25/2012	Scheduled Visit						
Note	195	2/24/2012	Scheduled Visit						
	194	2/23/2012	Scheduled Visit						
Edit	193	2/22/2012	Scheduled Visit						
Misc.	192	2/21/2012	Scheduled Visit						
Note	101	1000010	Cohedadadthait						1

2. Click the New Case button.

Tip: If using a linked external billing system DO NOT create new cases here.



Users can click the **Copy Other Case** button to copy information from one case to another. Learn more about copying case information by watching the Copy Case Information video.

The accident screen will appear with six different tabs that are outlined in this section. They are:

- Main
- History
- Accident Description
- Misc
- Summary
- Final Notes

### 4.4.1.1 Main Tab

- 1. select a **case**, if you haven't already.
- 2. Select the Main tab.

vg Case		-0.000
Miles History	Accident Description   Misc.   Summary   Final Notes   Klosk	
Description:	Lower Back	
Visits Allowed:	Type: Unknown	•
Accident / Problem Date:	2 Monday , February 01, 2010 @+ Auto Accident	•
Office:	SoftwordD630	•
Provider:	Solutions, DC, Softworx - Referred By:	· P
Claim #:	Ib Z45454554 lb Insured Name:	
Insurance:	Blue Cross Blue Shield	
Policy #:	Group # Copay:	
Fee Protie:	14104	
Status:	Active   Start Visit Count At	
Transitioned In:	From:	
Transitioned Out.	• To:	
Do NOT print (this is usually	SOAP opening sentence about patient being evaluated for care pla clicked for Welness patients) By on notes	2
	g Cae Description: Visits Allowed: Accident / Problem Date: Office: Provider: Claim II: Insurance: Policy II: Fee Profile: Status: Transitioned In: Transitioned In: Transitioned In: Transitioned In:	g Case         Image: History   Accident Description   Misc.   Summary   Final Notes   Klosk           Description:       Lower Back         Visits Allowed:       Type:         Unknown         Accident /         Problem Date:         Office:         SoftworkD630         Provider:         Solutions, DC, Softwork ● Referred By:         Claim #:       Ib 245454554 lb         Insurance:       Blue Cross Blue Shield         Policy #:       Group #:         Copay:         Fee Profile:         Status:       Active:         Transitioned In:       • From:         Transitioned Out       • To:         Do NOT print SOAP opening sentence about patient being evaluated for care plar (this is usually clicked for Wellness patients)         Print Referred By on notes

3. Enter information required.

Tip: Only the Office and Provider are required on this tab, everything else is optional.

- 4. Click Save.
- 5. Click the Close button.

## 4.4.1.2 Medical History Tab

- 1. Select a **case**, if you haven't already.
- 2. Select the History tab.

Tip: Information entered in the Medical History Opening and Closing sections should be written in complete sentences.

- 3. Enter a Medical History Opening if you would like any customized information to appear on the report.
- 4. Select the History Assist button to display the Medical History form.

al History	Medical Histor	ry 🗄		9	
Method History	Medical Care Current	Conditions Family History	Social History		
	Family Doctor:	Yes ONO			
	Name: Address	Dr. Krylo			
	Last Visit Date:	No Value	<b>3</b> •		
	Last Exam Date:	No Value	U.		
	Family Chiropractor	• Yes O No			
	Name:	Dr. Palmer			
	Address:				
	Last Visit Date:	No Value	<b>•</b>		
	Last Exam Date	No Value	8-		
	Surgery less then 5 years	🛛 Yes 🔹 No			
	Last Surgery Date	C D No Value	(J+		
	Surgery Reason:				

- 5. Fill out the information on the Medical Care tab.
- 6. Select the Current Conditions tab selecting the appropriate items.
- 7. Choose the Family History tab and enter the information.
- 8. Enter the Social History.
- 9. Select the Exit Worxflow button and you will find a custom paragraph summarizing the information input into the system.

#### IMPORTANT: Make sure that you do not type anything where the custom paragraph appears.

10. Enter a Medical History Closing if you would like any customized information to appear on the report. Information is automatically saved so you can now move on to another tab to enter information.
11. Click Save.

#### 4.4.1.3 Accident Description Tab

- 1. Select a case, if you haven't already.
- 2. Select the Accident Description tab.

#### Tip: Accident Description History Opening and Closing sections should be written in complete sentences.

- 3. Enter an Accident Description Opening if you would like any customized information to appear on the report.
- 4. Click the Accident Assist button.
- 5. Enter Accident and Post Accident information in the multiple windows.
- 6. Click the Exit Worxflow button. You should now see a custom Accident Description paragraph that has been created.



- 7. Select Save.
- 8. Select Close.

#### 4.4.1.4 Misc Tab

- 1. Select a **case**, if needed.
- 2. Select the Misc tab.
- 3. Enter all available information.

#### Tip: If this is a Workers Comp case, Employer Information may be important.

4. If you have entered Contra Indications, you may wish to select to have the indications pop-up when the patient record is loaded by placing a check in the box.

Main	History	Accident Description Misc Summary Final Notes   Klosk	
Emp	loyer:	Gotham City	
0000	upation:	Police Officer	
Work	Activity:	Light Labor -	
Job I	Duties:		
py			•
e Cont Indic	ra ations:	do not adjust o4/c5/	8
			ż
		Popup contra indications when patient is first selected	
Work	ult Exam diow;		•
Defa Work	ult SOAP		2
Euto	mal Case II	· · · · · · · · · · · · · · · · · · ·	

#### 4.4.1.5 Summary Tab

- 1. Select a **case**, if you haven't already.
- 2. Select the **Summary** tab.

3. The Summary tab allows you to draw and write on the front and back profiles that are troubling to the patient. As you can see from the example below, the neck and lower back region are highlighted as problems for the patient.

The drawing tools built into the software are the:

**Pen** (tool in blue): You can adjust the color, size, tip, transparency, and smoothness by clicking the drop down arrow next to the pen icon. You can then draw and write anything on the picture. Users can default the pen color so that it always starts on a certain color. Watch the Default Drawing Pen Color video to find out how.

**Highlighter** (tool in green) : You can adjust the color, transparency, tip, size, and smoothness by clicking the drop down arrow next to the highlighter icon. You can then highlight any area on the picture.

**Eraser** (tool in pink) : You can select the mode and size of the erase by clicking the drop down arrow next to the eraser icon. You can then erase any markings you have made on the picture.

**Lasso** (tool in orange) : You can draw around a large area with the lasso tool and it will then create a box around that area that you can use to move the marking you have made to different areas on the screen.



4. Select **Save** and **Close** when you are finished.

## 4.4.1.6 Final Notes Tab

- 1. Select a **case**, if you haven't already.
- 2. Select the Final Notes tab.

#### Tip: Final Notes should be written in complete sentences.

3. Enter any final notes or analysis that you would like to appear on the patients Final examination report.



- 4. Select Save.
- 5. Select Close.

## 4.4.1.7 Kiosk Tab

- 1. Select a case, if you haven't already.
- 2. Select the Kiosk tab.

0	Use this C	Case for Kiosk Chec ly, no need to do su	k-In bjective questions			
	Outcome 1:			Force on next K	iosk visi	
0		Then Every :	visits			
	Outcome 2:			<ul> <li>Force on next K</li> </ul>	iosk visi	
		Then Every :	visits			
	Outcome 3:			Force on next K	E Force on next Kicsk vis	
		Daily Living Assess Neck Disability Ind Oswestry Low Bar PDQ (Pain Disabil Roland Morris	ment ex ck ity Questionnaire)			

If the patient you are working with has more than one case, you want to make sure you select which case will be used for check-in using the kiosk, if you are using the kiosk. If the patient you are working with falls into a population that you feel couldn't use the kiosk or is fearful of the kiosk, then you can check sign in only, no need to do subjective questions. On this tab, you also have the ability to choose specific outcome assessments for this particular patient to take when they are using the kiosk. Choose how often you want this patient to take this assessment and you can choose to make them take this outcome assessment on their next visit.

## 4.4.2 Edit a Case

1. Search for the patient.

2. Select the doctor's bag button.

Patient H	istory							1.9	
	Cas	es			Include InActive				
X	No.	Description		First Visit	Last Visit	No. Visits	Status	Kiosk	
Close	1	Personal Injur	v	2/9/2010	5/21/2012	65	Active	Y	
Citore	2	Lower Back	S	2/11/2010	3/13/2012	206	Active		
New									
Case	Visit	s C							
Edit	No.	Date	Reason						10
Case	206	3/13/2012	Scheduled Visit						1
Charles and a	205	3/7/2012	Scheduled Visit						
	204	3/6/2012	Scheduled Visit						
New	203	3/5/2012	Scheduled Visit						
VISIT	202	3/2/2012	Scheduled Visit						
	201	3/1/2012	Scheduled Visit						
Edit	200	2/29/2012	Scheduled Visit						
Visit	199	2/28/2012	Scheduled Visit						
	198	2/27/2012	Scheduled Visit						
	197	2/26/2012	Scheduled Visit						
New	196	2/25/2012	Scheduled Visit						
Note	195	2/24/2012	Scheduled Visit						
	194	2/23/2012	Scheduled Visit						
Edit	193	2/22/2012	Scheduled Visit						
Misc.	192	2/21/2012	Scheduled Visit						
NODE	101	2000010	Coheddadthait					_	

3. Highlight the case and select the Edit Case button. Make changes as needed.

-	( intervel )			- Jance	100		1 1 1 1 1 1 1 1 1	ines [ receive ]	
Save	Description:	Lower Back							
	Visits Allowed:	Type: Unknown							
X	Accident / Problem Date:	Monda	y , Fet	bruary	01, 2	010 🖾	* Auto	Accident	
1054	Office.	SoftworxD6	30						
	Provider.	Solutions, D	C, Soft	vorx •	Refe	arred By	:		• P
	Claim #	\b Z4545455	i4 \b		Insu	red Nan	ne:		
ору	Insurance:	Blue Cross	Blue Shi	eld					•
10 MC	Policy #:			Grou	р#			Copay:	
	Fee Profile:								
	Status:	Active	•				Start V	isit Count At	
	Transitioned In:				•	From:			
	Transitioned Out.					To:			
	Do NOT print (this is usually	SOAP openi clicked for V	ng sente Veliness	nce ab patients	out p	atient be	sing eval	uated for care	plan
	P Driet Referred	Ry on notes							

Users can click the **Copy Other Case** button to copy information from one case to another. Learn more about copying case information by watching the <u>Copy Case Information</u> video.

- 4. Select Save.
- 5. Choose Close.

#### 4.4.3 Add a New Visit

- 1. Search and select a patient.
- 2. Select the doctor's bag button to display the **Patient History** screen.
- 3. Click the New Visit button.
- 4. The Add New Visit window will appear. Select the date of the visit using the calendar button as shown below.

Wednesday, April 09, 2008
---------------------------

- 5. Select a Visit Reason from the drop down menu. The visit options are:
- Consultation
- Exam
- Final Exam
- Initial Exam
- Schedule Visit
- Unscheduled Visit
- 6. Click Save.
- 7. Choose Close.

8. Depending on the type of visit for the patient, you will have the option of beginning a SOAP or an Exam. Click either the **Soap button** or the **Exam button** to continue entering notes.

## 4.4.4 Edit a Visit

1. Search and select a patient.

2. Select the doctor's bag button to display the **Patient History** screen as shown below.

Patient H	istory							1.9.	
-	Cas	es			Include InActive				
X	No	Description		First Visit	Last Visit	No Visits	Status	Kiosk	
Close	1	Personal Inju	ry.	2/9/2010	5/21/2012	65	Active	Y	
	2	Lower Back		2/11/2010	3/13/2012	206	Active		
New									
Case	Visil	S C							
5.41	No	Date	Daasoo						
Case	206	3/13/2012	Scheduled Visit						1
10000	205	3/7/2012	Scheduled Visit						
	204	36/2012	Scheduled Visit						
New	203	35/2012	Scheduled Visit						
Visit	202	3/2/2012	Scheduled Visit						
	201	3/1/2012	Scheduled Visit						
Edit	200	2/29/2012	Scheduled Visit						
Visit	199	2/28/2012	Scheduled Visit						
	198	2/27/2012	Scheduled Visit						
	197	2/26/2012	Scheduled Visit						
New	196	2/25/2012	Scheduled Visit						
Note	195	2/24/2012	Scheduled Visit						
11015	194	2/23/2012	Scheduled Visit						
Edit	193	2/22/2012	Scheduled Visit						
Misc.	192	2/21/2012	Scheduled Visit						
PN00e	101	1000010	Calendedadting						

- 3. Choose a visit and click Edit Visit.
- 4. Make the necessary changes, then select Save.
- 5. Choose Close.

## 4.4.5 Add New Miscellaneous Note

Information regarding the creation of a new miscellaneous note can also be found by watching the <u>Miscellaneous Notes/Missed</u> <u>Appointments</u> video.

1. Search and select a patient.

2. Select the doctor's bag button to display the **Patient History** screen as shown below.

Patient H	istory							9.00
	Cas	es .			Include InActive			
X	No.	Description		First Visit	Last Visit	No Visits	Status	Kiosk
Close	1	Personal Inju	ry	2/9/2010	5/21/2012	65	Active	Y
Citose	2	Lower Back	<u>.</u>	2/11/2010	3/13/2012	206	Active	
New Case						200		
	Visil	S C						
Edit	No.	Date	Reason					
Case	206	3/13/2012	Scheduled Visit					1
	205	3/7/2012	Scheduled Visit					
	204	3/6/2012	Scheduled Visit					
New	203	3/5/2012	Scheduled Visit					
VISIT	202	3/2/2012	Scheduled Visit					
	201	3/1/2012	Scheduled Visit					
Edit	200	2/29/2012	Scheduled Visit					
Visit	199	2/28/2012	Scheduled Visit					
	198	2/27/2012	Scheduled Visit					
	197	2/26/2012	Scheduled Visit					
New	196	2/25/2012	Scheduled Visit					
Note	195	2/24/2012	Scheduled Visit					
	194	2/23/2012	Scheduled Visit					
Edit	193	2/22/2012	Scheduled Visit					
Misc.	192	2/21/2012	Scheduled Visit					
NODE	101	10000010	Cabaddad Mak					7

3. Click the New Misc. Note button to create a miscellaneous note that will print along with SOAP notes the patient has.

4. Select a **Date** and **Note Reason**. Note reasons can be created under the Administration tab > Misc. Note Types.

5. Enter information needed in the note to print.

🛃 Add New I	Note		-? <b>-</b> X-
	Case:	Lower Back, First Visit: 2/11/2010	*
Save	Date:	✓ Tuesday , May 29, 2012	
	Note Reason:		-
Close	Note:	Authorization Confirmation Missed Appointment Phone Call - Lawyer Phone Call - Patient	
	P-14		
	Provider:	Solutions, DC, Softworx	•

6. Click  $\ensuremath{\textbf{Save}}$  and  $\ensuremath{\textbf{Close}}$  , when finished.

# 4.4.6 Edit Miscellaneous Note

1. Search and select a patient.

2. Select the doctor's bag button to display the **Patient History** screen as shown below.

Patient H	intery							17	12
	Cas	es		1.	Include InActive				
X	No.	Description		First Visit	Last Visit	No. Visits	Status	Kiosk	
Close	1	Personal Injury		2/9/2010	5/21/2012	65	Active	Y	
Citate	2	Lower Back		2/11/2010	3/13/2012	206	Active		
New								_	
Case	Visi	b C							
Edit	No.	Date	Reason						1
Case	56	5/1/2012	Exam						
	55	4/30/2012	Exam						
G.,	54	4/27/2012	Scheduled Visit						
New	53	4/20/2012	Scheduled Visit						
VISE	52	4/19/2012	Scheduled Visit						
	51	4/18/2012	Scheduled Visit						
Edit	50	4/17/2012	Scheduled Visit						
Visit		4/16/2012	Missed Appointment	nt					
	49	4/13/2012	Scheduled Visit						
	48	4/12/2012	Scheduled Visit						
Minc	47	4/11/2012	Scheduled Visit						
Note	46	4/10/2012	Scheduled Visit						
CITING STAT	45	4/9/2012	Scheduled Visit						
Edit	44	4/8/2012	Scheduled Visit						
Misc.	43	4/7/2012	Scheduled Visit						
14010	47	4000000	Cale of deal link						

- 3. Select the miscellaneous note to be changed.
- 4. Click the Edit Misc. Note button to edit a miscellaneous note that will print along with SOAP notes the patient has.



5. Click Save and Close , when finished.



Patient Reporting allows you to configure customized reports, view specific patient reports, run reports to be printed and email reports.

## 4.5.1 Run a Patient Report

1. Search and select a patient.



graph and stethoscope button and the **Patient Reporting** window will appear.



3. Select the **case** from the drop down menu to print the report. Then select the time frame for which you would like to run the report; you can select a specific date or print it for a specific time frame, you can select the last visit or a specified range of dates and print those visits.

#### Tip: For exam reports, run against the exact exam date. For example, initial exam run against the initial exam date.

4. Select the type of report from the listing in the reports window and click **Run** and your report will print to a Microsoft Word document.

5. Select close when you have finished.

#### 4.5.2 View a Prior Report

1. Search and select a patient.

2. Click the *weak* graph and stethoscope button and the **Patient Reporting** window will appear.

3. Select the View Prior Report button and you will be given a list of reports for that patient.

Reporting							
X	Patient Report Producing Rep	ing korts For : Bruce W	layne			E Include	InActive
Close	Case	Shoulder, First	Visit: 1/29/2010	)			•
	Time Frame :	· Last Visit	Other				*
Run		From Date:	2/ 5/2010	۵.	To Date:	2/ 5/2010	0.
View Prior Report	Reports XRay Report						ŕ
	SOAP Notes - SOAP Notes - Initial Exam Intermediate Ex	Paragraph Style Detail kam					
Report	Final Exam Permission to Work Excuse from Work						
	Letter Of Intent Dual Listing Ex Compare Visits	amination Report					
	Patient Graphin	na					-

4. There are three options in the Existing Reports windows.

View Existin	ng Reports				0
NV.	Reports For :	Bruce Wayne			
	Date	Time	Report Name	Contains	
Ciose	Jun, 22 2012	04:23:55 PM	SOAP Notes - COPY	2012/06/21	
	Jun, 22 2012	04:22:21 PM	Initial Exam	2010/02/11	
	Jun, 21 2012	02:24:31 PM	Final Exam	2010/02/09	
	Jun, 21 2012	01:39:13 PM	SOAP Notes - COPY	2012/06/21	
	Jun, 21 2012	01:36:49 PM	SOAP Notes - COPY	2012/06/21	
View	Jun, 21 2012	01:24:22 PM	SOAP Notes - COPY	2012/06/21	
1	Jun, 21 2012	01:22:55 PM	SOAP Notes - COPY	2012/06/21	
and the second	Jun, 14 2012	05:13:12 PM	Intermediate Exam	2012/06/06	
Mark As	Jun, 14 2012	05:12:23 PM	SOAP Notes - Paragraph Style	2012/06/13	
Sent	Jun, 14 2012	05:11:41 PM	SOAP Notes - COPY	2012/06/13	
1	May, 25 2012	11:22:33 AM	SOAP Notes - COPY	2012/03/13	
Drint	May, 25 2012	11:13:52 AM	SOAP Notes - COPY	2012/05/21	
P105	May, 25 2012	11:13:26 AM	SOAP Notes - COPY	2012/05/21	
	May, 25 2012	11:12:00 AM	Initial Exam	2012/03/13	
	May, 25 2012	11:11:34 AM	SOAP Notes - COPY	2012/03/13	
oMail	May, 21 2012	12:42:39 PM	SOAP Notes with exam	2012/05/21	
	May 21 2012	12 41 41 DM	SOAD Motor Durannah Shila	2012/05/21	1.

a) Highlight the report and click the **View** button for the report to appear in Microsoft Word for viewing, editing, and/or printing.

b) Highlight the report and click the Mark as Sent button for the report to be logged as sent out and highlighted.

Tip: When a report is Marked as Sent, it will show up highlighted in the list and on other machines. Otherwise, these reports will only show up on this machine.

- c) Highlight the report and click the **Print** button to print the report immediately.
- 5. Click **Close** when you are finished.

## 4.5.3 Report Configuration

- 1. Search and select a patient.
- 2. Click the graph and stethoscope button and the **Patient Reporting** window will appear.
- 3. Highlight the report to configure.
- 4. Select the **Report Config** button to see a screen similar to the one shown below.



5. You can now make changes to the organization of the report by using the **Up** and **Down** arrows. Select the information you would like to move using those arrows.

6. When you are finished making changes click close. Changes will be automatically saved in the system.

## 4.5.4 Emailing a Report

1. Search and select a patient.

2. Click the graph and stethoscope button and the **Patient Reporting** window will appear.

Reporting							-9-2		
X	Patient Reporti Producing Rep	Patient Reporting Producing Reports For : Bruce Wayne Include In							
Close	Case:	Unknown					•		
	Time Frame :	Last Visit	Other						
Run		Range From Date:	11/ 2/2011	G+	To Date:	11/ 2/2011	0-		
View Prior Report	Reports XRay Report					0.0000000000000000000000000000000000000	ł		
	SOAP Notes - Paragraph Style SOAP Notes - Detail								
	Initial Exam Intermediate Exam								
	Final Exam								
Report	Permission to 1	Work					_		
Config	Excuse from Work								
	Letter Of Intent								
	Compare Visite	amination Report					-		
	Letters								

3. Click on View Prior Report.

View Existin	ng Reports				-0
	Reports For :	Bruce Wayne			
	Date	Time	Report Name	Contains	1
Close	Oct, 27 2011	11:38:44 AM	SOAP Notes - Detail	2011/10/27	1.0
	Oct, 18 2011	05:45:56 PM	Final Exam	2010/05/20	
	Oct, 13 2011	11:34:53 AM	Letters	2011/10/13	
	Oct, 7 2011	11:53:36 AM	SOAP Notes - Detail	2011/10/07	
1	Sep, 27 2011	04.04.28 PM	Intermediate Exam	2011/09/27	
View	Sep, 23 2011	04:45:43 PM	SOAP Notes - Detail	2011/09/23	
	Sep, 23 2011	04:39:02 PM	SOAP Notes - Detail	2011/09/23	
	Sep, 23 2011	04:37:54 PM	SOAP Notes - Detail	2011/09/23	
Mark As	Sep, 23 2011	04:30:20 PM	SOAP Notes - Detail	2011/09/23	
Sent	Sep, 23 2011	04.28.32 PM	SOAP Notes - Detail	2011/09/23	
	Sep, 23 2011	10:10:58 AM	Initial Exam	2011/09/23	
Dist	Sep, 23 2011	10:10:09 AM	SOAP Notes - Detail	2011/09/23	
PODL	Sep, 23 2011	10:06:47 AM	SOAP Notes - Detail	2011/09/23	
	Sep, 22 2011	09:51:59 AM	SOAP Notes - Detail	2011/09/22	
eMail	Sep, 22 2011	09:51:22 AM	SOAP Notes - Detail	2011/09/22	
	Sep, 20 2011	01:54:37 PM	Initial Exam	2010/02/11	
	Sec. 20.2011	01-44-20 DAA	COAD Noton Dated	2011/00/20	

You will see all the reports that you have run for this patient on this machine. Other reports that have been run for this patient, but not marked as sent can be viewed on the machine that the report was originally run on. If it was marked as sent you will find the report her highlighted in yellow.

4. Click on the **report** you wish to email.

#### Note: You may only choose one report at a time to email.

5. Click on the eMail button to send the document to another doctor, attorney or receiving party.

😌 ExternalRe	porting				-9- <b>-</b>			
	Facility:	Downtown Office		•				
Close	File:	C:\Softworx Solutio	ns/ChiroWrite\outpu	#1_535_SNP_201	1_10_27_11_38_44_AM_C 📑			
	Transfer Method	t O FTP	# E-Mail					
	FTP							
Send Email	Host Name		Port 21	Anonyi	mous Secure			
	User Name:			Passiv	Mode     Implicit SSL     Explicit SSL			
	Password:							
	Upload Folder.							
	Email							
	To:			User Name:	ksisneros@softworxsolut			
	Cc.			Password:				
	Subject:			Advanced Ema	i Settings			
	Message:			Tatalood Child	i oouingo			
	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1			Server Address	mail softworksolutions.co			
				Port	26			
				Secure	(2) Authenticate			
				Implicit S	SL			
				and the second second	AT			

If you have not configured your email settings ahead of time this information will be blank, but you will need it to send an email from ChiroWrite. Configuration ahead of time is normally easier in this case. Please contact our office at 800.642.6082 so that we might assist you with setup. You can also head to section <u>3.2.23.1.11 Misc</u> for further instructions or you can learn more by watching the Email Patient Notes video.

6. Click the **Send Email** button if everything is filled out concerning who the email is to, the subject and an additional message you may want to send.

7. Select Close when you have finished.

### 4.6 Patient Notes

If you would like to add patient notes to the record you can follow the procedures in this section. These notes are not tied to any particular visit, but rather general notes specific to the patient. These notes will not print in the reports you run.

#### 4.6.1 New Notes

1. Search and select a patient.

2. Click the *pencil* button and the **Notes** window will appear.

3. Choose the New button and a screen will appear with two tabs: Hand Notes and Converted.

Using the pen tool or your Tablet PC pen write your notes on the screen for the patient, similar to the example below.

#### Note: Any notes enter for the patient here will not print on any of the reports.

The drawing tools built into the software are the:

**Pen** (tool in blue): You can adjust the color, size, tip, transparency, and smoothness by clicking the drop down arrow next to the pen icon. You can then draw and write anything on the screen.

**Highlighter** (tool in green) : You can adjust the color, transparency, tip, size, and smoothness by clicking the drop down arrow next to the highlighter icon. You can then highlight any area on the screen.

**Eraser** (tool in pink) : You can select the mode and size of the erase by clicking the drop down arrow next to the eraser icon. You can then erase any markings you have made on the screen.

**Lasso** (tool in orange) : You can draw around a large area with the lasso tool and it will then create a box around that area that you can use to move the marking you have made to different areas on the screen.

Notes		( V 🗖 🖉
Rotes	Hand Notes Converted Producent needs upper back X-rays.	
	411	

4. When you are done adding notes, click the **Convert** button.

5. View the notes after they have been converted to text by clicking the **Converted** tab. Using your keyboard, you can also add notes directly into the converted tab, by typing them in.

6. Click Save.

7. Select Close.

# 4.6.2 Edit Notes

1. Search and select a patient.

2. Click the

pencil button and the **Notes** window will appear.

- 3. Highlight the notes file to edit.
- 4. Choose the Edit button and the screen will appear with two tabs: Hand Notes and Converted.
- 5. Make any necessary changes and click **Save** when finished.
- 6. Select Close.

## 4.6.3 Print Notes

- 1. Search and select a patient.
- 2. Click the
- ck the _____ pencil button and the **Notes** window will appear.
- 3. Highlight the notes file and select Print.
- 4. After printing the notes, click close.
#### 4.7 Patient Images or Other Documents

The patient images section is where you can upload patient x-rays or other images to the patients profile. The images can be linked to be seen on the patients travel card for further use. This section can also be used for uploading other documents including scanned items or even video. You can also choose to have the images or scanned documents open using a native Windows program. Learn more by watching the <u>Images Should Open using Windows Default Program</u> video.

#### 4.7.1 Add New Patient Images

- 1. Search and select a patient to add images.
- 2. Select the **camera** button.
- 3. Click the New button.
- 4. Select the type of image from the drop down menu, which consist of the following:
- Mock-up
- Patient Intake Forms
- Patient Picture
- X-Rays
- 5. Select whether these are image files, by selecting the appropriate radio button.
- 6. Click the **Browse** button to select the path of the image file. When you have navigated to the proper path, highlight the file and select **Open**.

#### Note: Images must be in a shared directory that can be seen by all network computers.

7. Enter a description if necessary.

Tip: The Description should be written in complete sentences.

Tip: Images should be kept somewhat small so they don't interfere with system performance. Using a program like Microsoft Picture Manager can assist you with compressing the image, so that quality is not lost.

8. Place check in the box if you would like the image to display in the Summary window on the patients Travel Card.

9. When you have completed entering information into the Patient Image window, click Save.

10. Select Close.

A completed Patient Image screen would look similar to the screen shown below.



## 4.7.2 Edit an Existing Patient Image

- 1. Search and select the patient to edit the image.
- 2. Select the

camera button.

- 3. Highlight the image you would like to edit from the list that appears.
- 4. Click the Edit button.
- 5. Make any necessary changes and click Save.
- 6. Select Close.

#### 4.7.3 View Patient Images

- 1. Search and select the patient to edit the image.
- 2. Select the camera button.
- 3. Highlight the image you would like to edit from the list that appears.
- 4. Click View.

The drawing tools built into the software are the:

**Pen** (tool in blue): You can adjust the color, size, tip, transparency, and smoothness by clicking the drop down arrow next to the pen icon. You can then draw and write anything on the image.

**Highlighter** (tool in green) : You can adjust the color, transparency, tip, size, and smoothness by clicking the drop down arrow next to the highlighter icon. You can then highlight any area on the image.

**Eraser** (tool in pink) : You can select the mode and size of the erase by clicking the drop down arrow next to the eraser icon. You can then erase any markings you have made on the image.

**Lasso** (tool in orange) : You can draw around a large area with the lasso tool and it will then create a box around that area that you can use to move the marking you have made to different areas on the screen.



- 5. Make any necessary changes and click Save.
- 6. Select Close.

## 4.7.4 Change the Order of Patient Images

- 1. Search and select a patient whose images you need to view.
- 2. Highlight an image and click the Up and Down buttons to move them into the appropriate order.
- 3. Click **Close** when done.

## 4.7.5 Add a New Document

- 1. Search and select a patient to add images.
- 2. Select the **camera** button.
- 3. Click the **New** button.
- 4. Select the type of document you are adding from the drop down menu. Remember this can be edited to fit your needs.
- 5. Select **all files**, by selecting the appropriate radio button.

6. Click the **Browse** button to select the path of the file you wish to attach. When you have navigated to the proper path, highlight the file and select **Open**.

Note: Documents must be in a shared directory that can be seen by all network computers.

7. Enter a description if necessary.

#### Tip: The Description should be written in complete sentences.

- 8. Place check in the box if you would like the document to display in the Summary window on the patients Travel Card.
- 9. When you have completed entering information into the Patient Image window, click Save.
- 10. Select Close.

A completed Patient Image screen would look similar to the screen shown below.



### 4.7.6 Edit an Existing Document

1. Search and select the patient to edit the image.



camera button.

- 3. Highlight the document you would like to edit from the list that appears.
- 4. Click the Edit button.
- 5. Make any necessary changes and click Save.
- 6. Select Close.

## 4.7.7 View a Patient Document

- 1. Search and select the **patient** to edit the image.
- 2. Select the **camera** button.
- 3. Highlight the document you would like to edit from the list that appears.
- 4. Click View.

Depending on the type of document that is attached will dictate what program opens the document. For instance, PDF documents are usually opened with Adobe Reader and Word documents are usually opened in MS Word.

#### 4.8 Alerts and Messages

In ChiroWrite, you have the ability to create reminders for re-exams, filling out forms on a certain visit or setup other such warnings about other office protocols. You can also send messages from one ChiroWrite user to another. This is useful in a paperless environment where the doctor would like to communicate with the staff up front. Watch the <u>Alerts and Messages Video</u> for further information.

- 1. Select Administration > Alerts.
- 2. Click on **New** to create a new alert type.

😽 Edit Existi	ng Alert Type			8.0
	Description:	Every 12th visit		
	Туре:	· Scheduled Ale	rt O Instant Message	
Save	Occurs:	Every ? Visits		
X	Count	12 Specifi	c Visits	
Close	Show When:	Patient Selecte	ed OVisit Started	
	Message:	This is the12th w re-exam today.	sit, it is time for <firstlastname></firstlastname>	
	Status:	Active		
	Available Var	iables	7	
	First Na	me	<firstname></firstname>	
	First & L	ast Name	<firstlastname></firstlastname>	
	Title & L	ast Name	<titlelastname></titlelastname>	
	His/Her	(upper case)	< <u>His/Her&gt;</u>	
	He/She	(upper case)	<he she=""></he>	
	his/her (	lower case)	<u>shisher</u>	
	he/she (	lower case)	<he she=""></he>	
			officiant data and	

- 3. Enter in a **Description** that will allow you to easily tell what the alert type is.
- 4. Select Scheduled Alert as the type.
- 5. From the occurs drop down, select the interval in which this alert is to take place. The options include:
  - Next Time
  - Every Time

•

- Every ? Visits
- After ? Date
- Between ? Dates
- 6. Count allows you to determine the number of visits that need to occur before the alert goes off.
- 7. **Specific Visits** allows you to have the alert go off at a number of intervals. For example, you can put 3, 6, 9, 12 to have to alert go off on the 3rd, 6th, 9th and 12th visit.
- 8. Show When allows you to indicate when the alert shows up, if it is when the patient is selected or when their visit is started.

9. Enter a specific **Message** that you want to remind yourself of or alert your self to. There is no need to put in a specific message if the title or description is enough of a reminder.

10. Select Save and Close.

## 4.8.1.1 Creating an Alert



To create an alert, select a patient to work with by either searching for them using the selecting them from current patients.

magnifying glass button or



1. Select the

clock button.

2. Select New to create a new alert and a screen like the one below will appear.

Scher	dule Alert	Send Messag	e Now
Type: Occurs Count	Specific V	isits:	
Start Date:	Monday , Fe	bruary 15, 2010	9
End Date: Show When: Case:	Monday , Fe Patient Selected	bruary 15, 2010 Visit Started	0
Message:			

3. Select the **Type** of alert you want for this patient. The information will fill in accordingly and you can make changes as needed.

Note: If you do not have a type you can select from please proceed to section 4.8.1 to Create an Alert Type first.

- 4. Select Save.
- 5. Click Close.

# 4.8.2 Creating a Message Type

- 1. Select Administration > Alerts.
- 2. Click on New to create a new message type.

😴 Edit Exists	ng Alert Type			65	100
(100)	Description	Once a Wee	ik.		
	Туре:	C Scheduled	5 Alert	# Instant Message	
Save	Occurs:				
X	Count	Sp	ecific Vis	ts.	
Close	Show When:	O Patient Se	lected	Visit Started	
	Message	Reschedule	<firstlas< td=""><td>itName&gt; for once a week.</td><td></td></firstlas<>	itName> for once a week.	
	Status:	Active	•		
	Available Var First Na First & L His/Her He/She his/her (	ables: me ast Name ast Name (upper case) (upper case) lower case)		SFirstNames SFirstLastNames STiteLastNames StateShes StatShes ShistNes ShistNes	

- 3. Enter in a **Description** that will allow you to easily tell what the message type is.
- 4. Select Instant Message as the type.

5. Enter a specific **Message** that you want to send to another user. There is no need to put in a specific message if the title or description is enough of a message.

6. Select Save and Close.

### 4.8.2.1 Creating a Message

To create an alert, select a patient to work with by either searching for them using the selecting them from current patients.



magnifying glass button or



1. Select the

clock button.

- 2. Select New to create a new message and a screen like the one below will appear.
- 3. Select the Send Message Now button to get to the message screen shown below.

	Sch	edule Alert	Send Message No	w
ave	Type:	Once a Week		- 0
x	Send To	Max Eisenh	ardt	
lose		Kim Sisner	os	
		Softworx So	olutions	
		Charles Xa	vier	
	Message	Reschedule Bruce Wayne	e for once a week.	1

4. Select the **Type** of message to be sent to another user currently on the system.

Note: You cannot use the messaging feature if users have not been setup in ChiroWrite. Refer to section <u>3.2.8</u> for further information on creating users.

- 5. Select the Recipient of the message. To Whom is this message being sent.
- 6. Select Save.
- 7. Click Close.



The home icon take you out of all patient files and back to the original ChiroWrite home screen as it looked when you first opened ChiroWrite.



From here, you can navigate anywhere in the system or select **File > Exit** to close the system.

# 5.0 What's New?

The What's New? section provides users with a web-based document that has information about the current and previous releases. The information contained describes how to configure certain areas in the system, any new changes that have been added for a certain release and video tutorials that can assist users with configurable items within ChiroWrite. <u>View What's New?</u>

#### 6.0 Patient Scenarios

In ChiroWrite, you now have the ability to create exams of symptoms that you most often see in your office. It allows you to create and use a dummy patient to copy over exam information and allows you to make changes as necessary. Take a look at the Scenario Patient Video for additional assistance.

Note: This dummy patient only needs to be created in ChiroWrite and not in any external billing system if you are using one.

To turn this feature on, go to Administration > System Configuration > Defaults > Global 3 and check Enable Scenarios. You must exit the entire ChiroWrite system for changes to take effect.

System Se	ettings							
-	Global   Global 2 Global 3 Global 4   SOA	P SOAP 2	Printing Scanning	Copy Options   Patient Check In   Misc.				
	Current Patients Default Sort Order: © P	atient Name	© Time In					
Save	Incomplete Notes Default Sort Order: © V	isit Date	C Patient Name	O Provider				
х	Current Patients Name Display: • F	ull Name complete No	C First & Initial ites should follow this	<ul> <li>Initial &amp; Last rule also</li> </ul>				
Close	On Exit, ask if notes are complete: R	Jways	Only if note was	marked incomplete				
	E Launch Assignments after patient check	-in (Room, P	rovider, Visit Reason	0				
	Do NOT show missed checked-in appoir	ntments						
	Default Diagnosis Category:			-				
	Default Charges Category:			•				
	Print Provider Signature on: O Soap Notes	a 💿 Narra	tives 🔹 Both					
	Enable erase screen option (Enables the	erase scree	en button on the wor	(flow windows)				
	Use the term "Joint Dysfunction" instead	of "Sublocat	ion*					
	Enable Scenarios (System will ask if you	Enable Scenarios (System will ask if you wish to copy predefined Visit Scenarios)						
	Enable prior subluxations to be saved							
	Real Ask exam type when Exam button is clic	ked on Patie	nt Travel Card					
	Ask SOAP type when SOAP button is cl	icked on Pati	ent Travel Card					
	Nick Name Rule - how to display the patier	nt name if the	y have a nick name					
	Replace First Name with Nick	Name (does	s not effect reports)					
	Combine Nick Name into pati	ent name (do	es not effect reports	)				
	O Do Nothing							

Now when you click on **Exam Today**, the system will ask you whether or not to use a patient scenario to begin your exam rather than beginning from scratch.



# 6.0.1 Creating a Dummy Patient



1. Select the contact card with the green plus

2. Select a whether the dummy patient is male or female, and then enter in a first and last name for them. ( I.E. Low Back, Neck Injury)

button.

3. Select page 2 and check the Scenario Patient check box.

-	Page 1 Page 2			
ave	External Case / Reference Number:	WA01334		
	External Patient No:	WA013ZZZZZ		(Number visible in external system)
X	License No:			
ose	Marital Status:		•	
	Race:	White		
_	Ethnicity:	Not Hispanic or Latino	•	
ican	Preferred Language:	English		
	Preferred Contact	Phone		
	External Patient Id:			
	Scanned Id:			
	Check the box below patient that will be use	to indicate that this patient ed to copy predefined scen	is a t arios	scenario
		Scenario Patient		
	Status	-		

- 4. Select Save.
- 5. Click Close.

Now click on **Exam Today**, using your dummy patient the system will ask you whether or not to use a patient scenario to begin your exam rather than beginning from scratch. Select **No**.

Scenario Cl	neck	
?	Do you wish to copy a predefined Scenario?	
	Yes No	

1. Enter in information for the dummy patient's exam based on common symptoms and findings found in your office.



button.

Now you are ready to begin using the dummy patient's exam as a template for new patient exams. Simply click **yes** when prompted if you wish to copy a predefined scenario.

#### 6.0.2 Using the Scenario Patient

Whether you have a new patient or an existing patient for whom an examination is being completed, the scenario patient can be used to save time. The scenario patient can only be used with examinations at this time. If you have not setup patient scenarios yet, navigate to section 5.1 Patient Scenarios to begin the setup process first.

1. Select a patient either by searching for them using the **magnifying glass** or through **current patients**.

2. Click the Exam Today button



found on the patient travel card.



3. The system will ask if you wish to copy a predefined scenario. Click Yes.

PriorVisits	Ir	KY I	8 ×
	Select a s	cenario to copy	
Close	Patient: Lov	/ Back	
Church	Select the Neo If you wis Tes	/ Back k Injury t Scenario	
Сору	Case: Uni	nown, First Visit: 3/10/2010	
	Date	Туре	
	3/10/2010	Exam	

- 4. Select the scenario patient you want to copy information from in the drop down.
- 5. Be sure the exam shows up in the visits you can copy. Select the Visit.
- 6. Click the **Copy** button.
- 7. Simply tweak the exam based on the needs of this particular patient.

8. Exit the note when finished by clicking on the **Exit Worxfow** button.

### 7.0 How To

The how to section will be your guide to using the ChiroWrite system. In this section, you will be shown how to create an Exam Note, a SOAP Note, and how to print notes.

## 7.1 Exam Note

There are a couple of different ways to create an Exam Note. First, we need to select the patient we are going to be working with by

selecting the **magnifying glass** icon or selecting from the patients listed under **current patients**. Then, we need to determine if the note is for today or for a different date. If it is for today, then we can begin by clicking the **Exam Today** button found on the patient travel card. If the note is for a different day, then we can begin by clicking on the doctor's bag.

P 🗊 🖏	•	8/10	Total Volte: 36 Last Volt 676/2010		What's New?	2 🕑 🚱	
Patient Travel Card		1000 (1000 M			10		141
Ckse	LastExa Visits Sa	y 2  History   Trends   S28/200 History   Trends   S28/200 History   Trends   S28/200	Visits: 12	K	Cases	Lower Back, Last 6/16/2010, First 2/11/2010	
Visit Dates		WA.		Subluxa Area T11	Notes	Chief Complaint(s) Details 1, Lower Back	
SCAP Today		嬍	285	u		Pain Lover 4	
Exam LastVis	it Treatmen	nts					
Ares L1 L3 Shoulder T11	Right	Treatment Spinal Manipulation Spinal Manipulation Joint Manipulation Spinal Manipulation					
Shoulder	Right	Electrical Stimulatio SO-120 treg @ 25vo	n. Ra	Diagnos 724 5 307 81	5 12 - 2/11/2010 10 - 2/11/2010	Acute Low Back Pain NOS. Tension Headache	

7.1.1 Exam Note for Today

1. Select a patient either by searching for them using the **magnifying glass** or through **current patients**.



- 2. Click the **Exam Today** button found on the patient travel card.
- 3. Now you can begin entering information for your patient including their complaints, findings of their exam and their diagnosis.

P ChiroWrite			
File Administration Office Activiti	es Current Patier	nts Help	
P 🗊 鳎 🗳	• 🔫 🌶	/ 🐻	Patient Bruce Wayne Total Vesits: 36 Lest Vesit: 6/16/2010 What's New?
Standard Template •	Compla	ints	🗐 🖻 📝 🔣 🔗 🚳 🛛 Visit: 6/17/2010 🕖
Patient Complaints     Complaints		Opening Con	mments:
Daily Living Assesment			1
- Self Care/Hygiene - Communication			
-Normal Living - Sitting		Area	Details
-Normal Living - Lifting		1000	Criteria
Ambulation		1. Lower	Pain Level: 6
- Non Specialized Hand /	Complaint	Back	
- Sexual Function	Assist		
- Social & Recreational A		2. Left	
- The Effects Of Medicati		Shoulder	
- Pain Intensity - Pain Frequency			
Examination			
- Vital Signs - Mensuration Circumfere			
-Posture Station Observ			
- ROM Cenical - ROM Dornal			
- ROM Lumbar			
- ROM Shoulder		Charles Care	
-ROM Knee		Closing Com	amenis.
- ROM Wrist			
-ROM Ankle/Foot			
- Neuro Reflexes			
-Neuro Dermatome			
- Neuro Cerebellar			
< >			

## 7.1.2 Exam Note for Another Day

1. Select a patient either by searching for them using the magnifying glass ?.



- 2. Select the **doctor's bag** to enter the patient's visit history.
- 3. Click on the New Visit button to create a new visit for the patient with a different date.

Patient H	istory							L-Q-	-
	Cas	85		1	Include InActive				
X	No.	Description		First Visit	Last Visit	No. Visits	Status	Kiosk	
Close	1	Personal Inju	ry .	2/9/2010	6/26/2012	76	Active	Y	
Close	2	Lower Back	(5) (5)	2/11/2010	6/21/2012	207	Active		
New									
Case	Visi	s C							
Edit	No.	Date	Reason						1
Case	207	6/21/2012	Exam						1
	206	3/13/2012	Scheduled Visit						
a second	205	3/7/2012	Scheduled Visit						
New	204	3/6/2012	Scheduled Visit						
VISI	203	3/5/2012	Scheduled Visit						
	202	3/2/2012	Scheduled Visit						
Edit	201	3/1/2012	Scheduled Visit						
Visit	200	2/29/2012	Scheduled Visit						
	199	2/28/2012	Scheduled Visit						
	198	2/27/2012	Scheduled Visit						
New	197	2/26/2012	Scheduled Visit						
Note	196	2/25/2012	Scheduled Visit						
	195	2/24/2012	Scheduled Visit						
Edit	194	2/23/2012	Scheduled Visit						
Misc.	193	2/22/2012	Scheduled Visit						
Note	100	3/31/3013	Cabed dad 1642						

4. You can choose to copy an existing visit by selecting the visit you wish to copy and then clicking the Copy button. If you choose not to copy an existing visit simply click Close.

PriorVisits			0 ×
	Select a s	cenario to copy	
	Patient		
Close	Select the Vis If you wish to	it that you wish to copy and press the "Copy" button. start with a empty visit, press close.	
COPY	Case. Low	ver Back, First Visit: 2/11/2010	
	Date	Туре	
	6/17/2010	Exam	
	6/16/2010	Scheduled Visit	
	6/15/2010	Scheduled Visit	1
	6/14/2010	Scheduled Visit	
	6/11/2010	Scheduled Visit	
	5/20/2010	Final Exam	
	5/19/2010	Scheduled Visit	
	5/18/2010	Exam	
	5/11/2010	Scheduled Visit	

- 5. Change the date to the date of the exam and select the type of Exam it was.
- 6. Click Save.
- 7. Click Exam to go directly into the Exam note to enter information.



## 7.2 SOAP Note

There are a couple of different ways to create a SOAP Note. First, we need to select the patient we are going to be working with by selecting the magnifying glass icon or selecting from the patients listed under current patients. Then, we need to determine if the note is for today or for a different date. If it is for today, then we can begin by clicking the SOAP Today button found on the patient travel card. If the note is for a different day, then we can begin by clicking on the doctor's bag.



# 7.2.1 SOAP Note for Today

2. Click the SOAP Today button

1. Select a patient either by searching for them using the **magnifying glass** or through **current patients**.



found on the patient travel card.

3. Now you can begin entering information for your patient.

vp -	Subjective	🗐 🔄 📝 🔜 🛛 Visit: 6/18/2010 🕖	
SOAP Subjective Objective Assessment	Overall Pain Today: 000102 Overall Pain Today: 000102	03 04 05 06 07 08 09 010 (Excruciating) 03 04 05 06 07 08 09 010 (Excellent)	
Today's Treatments Charges Diagnosis SOAP Custom SOAP Custom 2 SOAP Custom 3	1. Lower Back Feeling: Better # Sar Pain Today: 0001020	ame Worse Show Details Edit Details 3 0 4 0 5 # 6 0 7 0 8 0 9 0 10 (Excrucialing)	
cture Body Picture Cenical Spine Picture Whole Spine Picture	2. Left Shoulder Feeling: O Better O Sar Pain Today: O O O O O O O	ame Worse Show Details Edit Details 3 0 4 0 5 0 6 0 7 0 8 0 9 0 10 (Excruciating)	
	Comments.	-	

## 7.2.2 SOAP Note for Another Day

- 1. Select a patient either by searching for them using the **magnifying glass**  $\mathcal{P}$ .
- 2. Select the **doctor's bag** to enter the patient's visit history.
- 3. Click on the New Visit button to create a new visit for the patient with a different date.

Patient H	istory							[	-
	Cas	85		E	Include InActive				
X	No.	Description		First Visit	Last Visit	No. Visits	Status	Kiosk	
Close	1	Personal Injun	y	2/9/2010	6/26/2012	76	Active	Y	
CIGHT	2	Lower Back		2/11/2010	6/21/2012	207	Active		
New									-
Case	Visi	s C							
Edit	No.	Date	Reason				_	_	
Case	207	6/21/2012	Exam						1
	206	3/13/2012	Scheduled Visit						
1 control	205	3/7/2012	Scheduled Visit						
New	204	3/6/2012	Scheduled Visit						
VISI	203	3/5/2012	Scheduled Visit						
	202	3/2/2012	Scheduled Visit						
Edit	201	3/1/2012	Scheduled Visit						
Visit	200	2/29/2012	Scheduled Visit						
	199	2/28/2012	Scheduled Visit						
	198	2/27/2012	Scheduled Visit						
Misc	197	2/26/2012	Scheduled Visit						
Note	196	2/25/2012	Scheduled Visit						
	195	2/24/2012	Scheduled Visit						
Edit	194	2/23/2012	Scheduled Visit						
Misc.	193	2/22/2012	Scheduled Visit						
LACO6	100	3/31/3013	Cabad dad Main						-

4. You can choose to copy an existing visit by **selecting the visit you wish to copy** and then clicking the **Copy** button. If you choose not to copy an existing visit simply click **Close**.

PriorVisits			2 ×
	Select a s	cenario to copy	
	Patient.		
Copy	Select the Vis If you wish to Case: Low	it that you wish to copy and press the "Copy" button. start with a empty visit, press close. wer Back, First Visit: 2/11/2010	
	Date	Туре	
	6/17/2010	Exam	
	6/16/2010	Scheduled Visit	
	6/15/2010	Scheduled Visit	1
	6/14/2010	Scheduled Visit	
	6/11/2010	Scheduled Visit	
	5/20/2010	Final Exam	
	111111111111111111111111111111111111111	Cabadulad Mail	
	5/19/2010	Scheduled Visit	
	5/19/2010 5/18/2010	Exam	

- 5. Change the date to the date of the SOAP and select the type of visit it was.
- 6. Click Save.
- 7. Click **SOAP** to go directly into the SOAP note to enter information.



# 7.3 Printing

The printing section covers how to print Exam notes and how to print SOAP notes. It also covers how to print notes that have already been sent out of your office.

# 7.3.1 Printing Exam Notes

1. Select a patient by searching for them using the **magnifying glass**  $\mathcal{P}$ .

2. Select the graph and stethoscope reporting icon 🥳.



X	Patient Reportin Producing Rep	ng orts For : Bruce W	/ayne			Include	InActive	
Close	Case:	Case: Lower Back, First Visit: 2/11/2010				-		
Run	Time Frame :	Last Visit     Range     From Date:	Other 6/18/2010	0.	To Date:	6/18/2010		
View Prior Report	Reports XRay Report SOAP Notes - 1 SOAP Notes - 1 Initial Exam Intermediate Ex	Paragraph Style Detail am						
Report Config	Final Exam Permission to V Excuse from W Letter Of Intent Dual Listing Exa	Work /ork amination Report						

- 3. Select the **Type of Report** to be printed under reports section.
- 4. Select **Other** for the time frame and select the actual **Exam Date** from the drop down.
- 5. Click the Run button to create the report in Microsoft Word.

To exit the report, **Close** the document and you will be returned to ChiroWrite.

6. Click Close, if finished.

# 7.3.2 Printing SOAP Notes

- 1. Select a patient by searching for them using the **magnifying glass** *P*.
- 2. Select the graph and stethoscope reporting icon 🥳.

	Datient Reporting						and the second second
N.	Patient Reporting	Dougo Mi				III Inchula	In A other
	Producing Reports For .	Bruce wa	зупе				InActive
Close	Case: Lower	Back, Fi	st Visit: 2/11/201	10			
	Time Frame : East	Visit	O Other				
Run	Ran	20	0/10/2010	-	To Date:	0100010	
	From	i Date.	6/18/2010	U.+	To Date.	6/18/2010	
View	Reports						
Report	XRay Report						
	SOAP Notes - Paragrap	h Style	1				
	SOAP Notes - Detail						
	Initial Exam						
	Intermediate Exam						
	Final Exam						
Report	Permission to Work						
Config	Excuse from Work						
	Letter Of Intent						
	Dual Listing Examination	Report					
	Compare Visits						
	Patient Graphing						

3. Select the **Type of Report** to be printed under reports section. Paragraph style prints the same information as the Detailed does just without headings.

4. Select either Last Visit or Range for the time frame and select the dates for the reports to run from the drop downs.

5. Click the Run button to create the report in Microsoft Word.

To exit the report, Close the document and you will be returned to ChiroWrite.

6. Click Close, if finished.

## 7.3.3 Printing Sent Notes

1. Select a patient by searching for them using the magnifying glass

- 2. Select the graph and stethoscope reporting icon  $\Im$ .
- 3. Click on the **View Prior Report** button.

View Existin	ng Reports				-9- <b>X</b>
	Reports For :	Bruce Wayne			
	Date	Time	Report Name	Contains	
Close	May, 28 2010	02:27:49 PM	Intermediate Exam	2010/05/18	1
	May, 27 2010	02:50:10 PM	Letters	2010/05/20	
	May, 27 2010	02:48:01 PM	Letters	2010/05/20	
	May, 27 2010	02:45:48 PM	Letters	2010/05/20	
	May, 27 2010	02:45:02 PM	Letters	2010/05/20	
View	May, 25 2010	01:31:32 PM	Dual Listing Examination Report	2010/02/11	
	May, 20 2010	01:35:24 PM	Intermediate Exam	2010/05/20	
	May, 20 2010	01:35:03 PM	Final Exam	2010/05/20	
Mark As	May, 20 2010	01:32:27 PM	Final Exam	2010/05/20	
Sent	Apr, 27 2010	12:21:24 PM	Letters	2010/04/27	
	Apr, 27 2010	12:19:35 PM	Letters	2010/04/27	
Drint	Apr, 27 2010	12:05:54 PM	Letters	2010/04/27	
- 146	Apr, 27 2010	12:01:41 PM	Initial Exam	2010/04/27	
	Apr, 16 2010	01:26:26 PM	SOAP Notes - Detail	2010/04/16	-

4. Select a report that has been highlighted yellow because it has already been sent out of the office.

5. Click **View** to bring up the report in Microsoft Word. There you can print the note as you normally would. OR click **Print** to simply print the note.

6. Click Close when finished.

# 8.0 ChiroWrite Video Library

The ChiroWrite Video Library was created to give providers resources they can access 24 hours a day 7 days a week to learn and understand how to use the software to their advantage. The lists are organized by release.

Release 2.1 Overview 2.1 SOAP/Exam more Integrated Report Sentence Structure 

 Multi Patient File Option

 Miscellaneous Notes/Missed Appointments

 Treating Provider

 Changing Report Names and Templates

 Custom Buttons Drag and Drop Feature

 Copy Case Information

 Default Drawing Pen Color

 WorxPhrase Symbols Added to Prognosis, Narrative Intro and Narrative Ending

#### Release 2.0

Overview 2.0 .NET Update ROM Default - Pain Default "No" Added Dynamic Notes for Orthopedic Test Sections Images Should Open using Windows Default Program Hide Phone Number in Search Window Expanded Subluxation List on the Travel Card Kiosk Force Complaints Diagnostic Orders Patient Education Generate Patient Lists Diagnosis History

**Email Patient Notes** 

#### Release 1.7

Overview 1.7 Patient Check-In Module - Kiosk Exercise/Activity Log Mass Maintenance Visit Surfing SOAP/Exam Integration Report Unit Charges Didn't Mean to Close?

#### Release 1.6.

Overview of 1.6

#### Release 1.5

Overview 1.5 Patient Scenarios Subluxation History No Copy Option Dual Treatment Areas Dual Images in Today's Treatments

#### Release 1.4

Overview 1.4

Current Patients ScreenSOAP LightSOAP CustomLettersAlerts and MessagesAudit LogProvider SignatureDynamic Lists

## 9.0 ChiroWrite 101

ChiroWrite 101 was created to give new and regular users alike a video tutorial area of how to do things in ChiroWrite. Enjoy!

<u>ChiroWrite Icons</u> <u>Configuration 101</u> <u>SOAP Note for Today</u> <u>SOAP Note for a Different Day</u> <u>Exam Note for Today</u> <u>Exam Note for a Different Day</u> Print Reports