File Review	Yes	No	Notes/page #
General Rules			
All pages have clinic name?			
All pages have clinic address?			
All pages have patient name, DOB or unique identifier?			
Were full and accurate records provided?			
New Patient			
Is there a chief complaint?			
Date of onset?			
Etiology or chronology of the problem?			
Aggravating or relieving factors?			
Prior treatment for this problem?			
Review of patient health history? Via forms or SOAP			
Medications reviewed?			
Illnesses reviewed?			
Psychosocial history reviewed?			
PARQ documented or informed consent signed?			
Height?			
Weight?			
Blood pressure?			
Pulse?			
Examination/Ortho/PARTs findings?			
Treatment plan?			
Treatment for the day?			
Response to treatment recorded?			
Is imaging/diagnostic testing clinically relevant?			
Follow Up Visits			
Subjective recorded?			

Objective has 2 of 4 of the PARTS anacronym?			
Treatment provided?			
Response to treatment recorded?			
For therapies are times and specifics listed?			
Does billing match the SOAP notes?			
Is there evidence of upcoding and/or excessive treatment?			
Is there a legible signature (typed name next to signature)?			
Does it state who did the treatment if there was someone else?			
Is there a date of service?			
Are the dates of service unique enough from visit to visit?			
Can another doctor read these notes and provide care?			
Is there appropriate clinical justification for care?			
Do x-rays meet minimum standards?			