Dynamic Chiropractic

DIAGNOSIS & DIAGNOSTIC EQUIP

Don't Trust What Your Patients Say

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When a patient presents to the office for care, they typically have a specific complaint – lower back pain, whiplash, sinus congestion, sciatica, etc. They are often not interested or engaged in what they consider "unrelated" personal health history. However, the standard of care dictates that we cover those bases.

In my practice, I have a mental checklist I run through for a basic health history and review of symptoms. This often rounds out my clinical understanding of the patient's health background, and it usually covers most of the "meaningful use" information we are now required to document.

If You Want the Right Answers, Ask the Right Questions

To get the information and background you need, don't be afraid to ask different questions. This only helps you to be more complete in your documentation. It doesn't have to take a lot of time, but it does require some conscious engagement on the part of the interviewer.

A good example is blood pressure. During the interview, I often ask the patient if they have any issues with circulation or blood pressure. The common response is "No" – but if you follow up and ask about medications, they will list five different prescriptions for blood pressure and cholesterol! Quite often the patient will assume that since they are on the medications and everything is "normal," they don't need to tell you about it.

Not all patients are intentionally deceitful – some just don't make the connection – but make sure to cover the bases. You have to look beyond the direct answer and tie all the information together to come up with a complete clinical picture.

Another common background note is surgery. Many patients state they have no surgical history, but then when you ask about their eyes, they will tell you their vision has been great since they had Lasik last year; or maybe they've had some gut problems since having their gallbladder removed. Many times patients just forget they had a surgery until you remind them.

I had a patient who denied surgery, but then when I asked about the scar at the navel, they responded, "Oh, that's from my laparoscopy last year"? Often patients consider these type of things a "minor procedure" instead of a legitimate surgery. Wisdom teeth removal, cholecystectomy, hernia repair, arthroscopy, tubes in the ears – these are all legitimate surgeries that should be noted in the history.

Documentation and the Power of a Thorough History

With the impending change to ICD-10 and the new standard of care for documentation, it is critical that you take the time to get a complete and accurate history. Having a good understanding of the patient's history is key – previous injuries, medications, allergies to medications, allergies, family history, and previous types of treatment are all relevant information.

Some patients may even be a little surprised when you ask about other aspects of their health care. A few of my patients did not feel I had any business knowing about more than just the spine – but as physician providers, it is our responsibility to review and document the scope of each patient's history. This can become more significant when dealing with an injury claim; knowing if there were a similar injury in the past and documenting that up front can save you a lot of headache down the road.

The case history doesn't always stop with the interview, either. As you physically evaluate the patient, you may uncover findings – bumps, scars, etc. – that warrant further questions. I noted above the patient with a laparoscopic scar who denied having surgery. You may have a patient who denies cardiovascular issues, but has pitting edema and stasis dermatitis in the legs. On palpation, you may find a lipoma on the back that the patient did not even know about. Any of these findings would warrant questions to fully round out your case history notes.

Don't be afraid to talk to patients. They came to you for care and most people like to talk about themselves,[1] so if you ask good questions, you can get them to provide considerable information about their condition. If you can take a good history, you should have a clear idea of what the condition and diagnosis are before you start your exam. At that point, your exam is just to confirm your clinical impression and specify the findings.[2]

The Responsibilities of Responsible Patient Care

Some docs I know have their staff "do the note stuff" and then they just come in and deliver the adjustment. I am sure some providers find taking the time to interview a patient time-consuming drudgery – but it is vital to establishing the doctor-patient relationship. Moreover, covering all bases – case history, health history, review of systems, medications, allergies, etc. – will only serve to make your documentation and case management better.

I've shared several times in the past that we must think outside the chiropractic bubble and in terms of health care in general. Ultimately, it is the patient we take care of - not the insurance companies, attorneys or other doctors. Whether or not you feel obligated to document all aspects of a case, responsible patient care mandates it.

References

1. Carnegie D. *How to Win Friends and Influence People*. Originally published in 1936.
2. Taught to me by Dr. Phil Paone, my good friend, mentor and orthopedic exam instructor at Palmer College.

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