Clinic Orientation — Learning Objectives

	Policies, Procedures, and guidelines	Notes
	Determine the daily work schedule (min. 16 hrs/week T8, 17 hrs/week T9; max. 22)	
	Provide intern with a tour of the clinic	
	Introduce intern to all key office personnel and their function	
	Show intern the flow of the practice	
	Assign intern a work space	
	Provide intern with a working knowledge of your Office Policy and Procedure Manual, including clinic dress code food in the clinic parking telephone use chain of command interacting with staff/boundary expectations vacation/time off (in correlation with the NWHSU Clinic Handbook)	
	Establish a weekly meeting time with the intern	
	Establish timing goals for: moving from observation to full participation meeting requirements (adjustments, exams, x-rays)	
	Determine how the intern will be referred to in the office "Doctor" is not an option "Chiropractic Intern" nametag must be worn at all times	

	Professional Behavior	Notes
	Punctuality	
	Maintaining confidentiality	
	Language	
	Interaction with staff	
	Interaction with patients	

History Learning Objectives

	Health History	Notes
	History Components	
	Establish the purpose of the patient's visit	
	Conduct an efficiently organized, smooth-flowing history	
	Past, family, medical, review of systems, lifestyle	
	Communication Skills	
	Demonstrate interpersonal skills: establishing/maintaining rapport with patients	
	Recognize, describe, and interpret the patient's verbal and non-verbal affective behavior during the history	
	Documentation	
	Understand that the admittance form and history initiate the patient's permanent record	
	Write an accurate, concise narrative summary of the patient's history	
	Know how and when to record pertinent and potentially sensitive clinical information provided by the patient during the history	
	Clinical Thought Process	
	Develop an initial list of differential diagnoses	
	Establish priorities for the scope and focus of the examination	
	Be able to prioritize and manage the history of a patient with multiple health complaints and concerns	
	Be able to identify common causes of and manage difficult doctor-patient encounters and relationships	

Physical Examination — Learning Objectives

	Physical Exam	Notes
	Exam Procedures	
	Be able to perform a smooth flowing, valid, and reliable exam in all these categories: brief · extended limited · comprehensive	
	Be able to perform appropriate and complete exams in these categories: spinal · general extremity	
	Communication Skills	
	Give appropriate gowning instructions	
	Give instructions in a clear, understandable manner	
	Documentation	
	Appropriately record examination results	
	Write an accurate, concise narrative summary of the patient's physical examination	
	Clinical Thought Process	
	Determine a clinically appropriate exam	
	Determine the appropriate attire for the patient's examination, and give thorough instructions	
	Redirect the flow and scope of the exam as clinically significant findings are discovered	
	Understand the necessity and timing of reevaluating the patient	
	Apply appropriate examination skills for dealing with challenging patients and unusual situations	
	Be able to recognize signs of patient abuse or neglect and understand appropriate reporting policies	
	Be able to recognize and evaluate patient presentations requiring referral - immediate and non-immediate	

X-ray	Learning Objectives

	Radiographic Examination	Notes
Clinical Thought Process		
	select appropriate x-ray studies as clinically indicated	
	determine appropriateness of radiographic consultations	
	demonstrate knowledge of when, how and to whom to make a referral	
	describe appropriate follow-up x-rays	
	understand the reasoning for ordering CT, MRI, nuclear medicine and other advanced imaging when appropriate	
Communication Skills		
	give appropriate gowning instructions (includes removing all potential artifacts)	
	instruct patient for proper positioning	
	be able to initiate appropriate radiologic consultations	
X-ray Room and Darkroom Procedures		
	demonstrate proper set-up – positioning, measurement, factors, marker, shielding	
	perform sensi-densi procedures	
	demonstrate procedures – lighting, reloading, flash card, processing	
	perform x-ray processor cleaning and maintenance	
Interpretation		
	recognize, interpret, and clinically correlate findings on plain film radiographs	
	be able to locate, understand and explain the significance of findings described in radiological reports of advanced imaging studies	
Documentation		
	conduct appropriate documentation - log book, report writing	
	be able to summarize radiographic findings in a written report	

Lab	Learning Objectives

	Laboratory Examination	Notes
	Clinical Thought Process	
	Be able to select clinically indicated tests	
	Be able to select clinically indicated follow-up tests	
	Understand when it is appropriate to refer a patient based on laboratory findings	
	Interpretation	
	Recognize, interpret, and clinically correlate findings of laboratory tests	
	Communication Skills	
	Be able to discuss the necessity for ordering clinically indicated tests with the patient	
	Be able to appropriately discuss test results with the patient	
	Documentation	
	Use appropriate documentation	

Diagnosis Learning Objectives

	Diagnosis	Notes
	Clinical Thought Process	
	Determine a diagnosis consistent with patient work-up	
	Be able to determine and prioritize the diagnoses for a person with multiple problems	
	Terminology	
	Understand the ICD-9 coding system and its appropriate use	
	Understand how to develop a written diagnosis and its appropriate use	
	Documentation	
	Understand the importance of properly documenting a diagnosis	
	Be able to write a diagnosis that is appropriate for a narrative report	

Treatment Plan

Learning Objectives

	Treatment/Management Plan	Notes
	Clinical Thought Process	
	Develop a management plan consistent for the diagnosis	
	Be able to appropriately modify the treatment plan after reevaluating the patient	
	Content	
	Adjustments Physiotherapy Soft tissue techniques Exercise Dietary counseling Nutrition therapy Home care Lifestyle modification Supports Patient education Referral Frequency of care Treatment goals Restrictions	
	Be able to assess and manage an exacerbation of the patient's primary condition	
	Be able to design and implement treatment plans for patients with multiple health problems and/or factors which complicate the care of the primary condition	
	Be able to take actions necessary to restrict work, activities of daily living, and recreational activities when appropriate, and be able to design and implement a plan for resuming these activities	
	Documentation	
	Be able to write a plan for managing the patient	

Report of Findings   Learning Objectives

	Report of Findings	Notes
	Clinical Thought Process	
	Determine for each patient the appropriate time and location of presentation	
	Determine appropriate presentation style based on patient's personality and needs	
	Content – discuss with the patient:	
	The outcome of the examination, x-rays, lab tests or other diagnostic studies	
	The mechanism responsible for the patient's symptoms or condition	
	Treatment, management and self-care recommendations work restrictions, activities of daily living and recreational activities when appropriate goals for care that are consistent with the expectations, needs, and health status of the patient prognosis An appointment schedule	
	Be able to participate with the patient in identifying goals for care that are consistent with the expectations, needs, and health status of the patient	
	Process	
	Timing / location	
	Visual aids / patient materials/handouts	

Therapeutic Procedures — Learning Objectives

	Therapeutic Procedures	Notes
	Adjusting	
	Understand the indications and contraindications for the adjustment	
	Select and apply the appropriate adjustment (manual and non-force) Spine/pelvis – cervical, thoracic, lumbar, sacrum, pelvis All joints of the upper and lower extremities	
	Physiotherapy	
	Understand the indications and contraindications for use	
	Be able to select the appropriate therapy for each patient	
	Be able to appropriately and effectively apply therapies	
	Supports/Braces, Exercise, Nutrition	
	Be able to select, fit and apply appropriate spinal and extremity supports	
	Be able to use appropriate exercise protocols, and instruct patients in their use for improving posture, coordination, strength, endurance and flexibility	
	Be able to provide patients with general nutritional information, specific dietary advice and appropriate supplement recommendations when clinically indicated	
	Lifestyle	
	Understand how to promote healthy behaviors and provide appropriate lifestyle modification information to patients as clinically indicated	
	Reevaluation	
	Understand the necessity for reevaluating the patient	
	Understand that reevaluation includes history, physical exam, potentially x-ray/lab, and modifying the diagnosis and treatment plan	

Record-keeping Learning Objectives

	Record-keeping	Notes
	Clinical Thought Process	
	Understand the appropriateness of how and when to document	
	Understand the circumstances in which there is a need to document out-of-office instructions given to the patient	
	Understand the importance, both legal and ethical, for maintaining patient confidentiality	
	File Documentation	
	Maintain accurate, current, understandable and legible records	
	Document initial and subsequent history, physical, diagnostic imaging and laboratory examinations	
	Record changes in the treatment plan	
	Record referrals to other providers	
	Use commonly accepted systems for coding diagnoses and clinical procedures	
	Recognize that billing and payment information is a legal component of the patient record	
	Communication	
	Be able to write narrative reports	
	Maintain a record of all professional communication written and verbal communication with patients	
	Understand and utilize appropriate records release procedures	
	Storage	
	Understand and utilize appropriate record storage	

Communication Learning Objectives

	Communication	Notes
	Demonstrate effective communication skills appropriate for professional and community interaction. written verbal non-verbal	
	Use words and phrases the patient can easily understand	
	Develop a professional doctor-patient relationship show genuine interest and concern for the patient display a professional demeanor towards the patient	
	Effectively give instructions to the patient	
	Explain the rationale and purpose for examination, laboratory, specialized diagnostic, and treatment procedures to patients	
	Demonstrate the ability to produce professional correspondence	
	Obtain and document informed consent	
	Develop a professional doctor-patient relationship and understand how it affects compliance with treatment recommendations and self-care instructions, as well as patient satisfaction and professional liability exposure.	
	Demonstrate an ability to educate and inform both patients and community about the profession, principles and practice of chiropractic	

Patient Education

Learning Objectives

	Patient Education	Notes
Home care		
	Be able to explain home care procedures to the patient in detail	
	Give handouts with instructions when appropriate	
Philosophy		
	Be able to describe the conceptual models of the subluxation	
	Be able to explain the frequency of care difference between chiropractic and allopathic medicine	
	Be able to describe the different phases of care	
	Be able to discuss how spinal nerve interference can be related to visceral problems	
	Be able to explain to the patient the importance of their responsibility in getting better	
	Be able to explain to the patient why self-adjusting is detrimental even though it feels good at first	
	Demonstrate the ability to put design and present a spinal care class	