Guidelines for Massage Therapy Initial Scoring Tool

Identification

At least once somewhere in the file - 1 point for each element	
1	Patient* name
1	Patient unique ID number or DOB
1	Provider name
1	Provider address
1	Provider phone
Every page of the file	
3	All elements are present on all pages.
2	Most elements are present on most pages.
1	Some elements are present on some pages.
0	No elements are present on any page.
Dates of Treatment	
2	The date is noted on every date of service.
1	The date is noted on most dates of service.
0	The date of service is not noted at all in the charts.

Signature	
3	The author of record is legibly identified, and the chart note is signed by hand or digitally or initialed at the end of each date of service.
2	The author of record is legibly identified, and the chart note is signed by hand or digitally or initialed at the end of every page.
1	The author of record is not legibly identified, and the chart note is signed or initialed at the end of each date of service or page.
0	The author of records does not sign their chart notes.

Clinical Information

Informed Consent: PARQ = Procedures, Alternatives, Risks, Questions	
5	Informed consent fully documented with patient's signature.
4	The provider documents PARQ discussion and no patient signature.
3	The provider documents three parts of PARQ elements/discussion.
2	The provider documents two parts of PARQ elements/discussion.
1	The provider documents one portion of PARQ elements/discussion.
0	The provider does not document any PARQ discussion.

*For CHP purposes all members are referred to as "patient" rather than client.

Patient Chief Complaint(s)/Comments	
3	The patient's chief complaint(s) are noted on every date of service.
2	The patient's chief complaint(s) are noted on most dates of service.
1	The patient's chief complaint(s) are noted on some dates of service.
0	There are no patient complaints on any dates of service.

Interval Changes	
3	The provider documents interval changes on every date of service.
2	Changes in the patient's condition are noted on most dates of service.
1	Changes in the patient's condition are noted on some dates of service.
0	There is no indication of interval changes on any dates of service.

Findings	
3	The provider documents their findings on every date of service.
2	The provider documents their findings on most dates of service.
1	The provider documents their findings on some dates of service.
0	There are no findings documented in on any dates of service.

Treatment, Procedures & Plans	
3	Are listed on all dates of service.
2	Are listed for most dates of service
1	Are listed on some dates of service.
0	There is no treatment, procedures or plan documented on any dates of service.

Return/Follow-up information	
3	The provider documents return and follow up info on every date of service, e.g. PRN.
2	The provider documents return and follow up info on most dates of service, e.g. PRN.
1	The provider documents return and follow up info on some dates of service, e.g. PRN.
0	There is no return or follow up info documented.

Clerical

Legibility	
3	Notes are typed.
2	Can read most without difficulty.
1	Can read some without difficulty.
0	Cannot read the notes at all.

Sufficient space for the information	
1	There is enough space to write an adequate chart note, e.g <3 visits per page.
0	There is not enough space to write an adequate chart note, e.g. >3 visits per page.

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