Patient Name:		Age:	Gender: M F O	Weight: lbs kg
Emergency Contact:	Relationship to Patient:	Phone #:		

Scene	**A**llergies	
	Medications	
	Past history	
	Last ins/outs	
	Events	

Symptoms (for chief complaint):

Physical Exam

Spine Assessment	☐ New Spine Pain	☐ Spine Pain on Palp
Time: a.m. p.m.	☐ Sensory Exam: Hand	☐ Sensory Exam: Feet
☐ Reliable	☐ Motor Exam: Hands	☐ Motor Exam: Feet

Report Completed By:	Date:
Signature:	Time: a.m. p.m.
Additional Care Giver:	
Additional Care Giver:	

Vitals

Time	AVPU	Heart Rate	RR	Temp	Other
a.m. p.m.	A V P U				
a.m. p.m.	A V P U				
a.m. p.m.	A V P U				
a.m. p.m.	A V P U				
a.m. p.m.	A V P U				

Assessment

Problem List	Anticipated Problem	Treatment	Plan

Patient Treatment Log

Time	Treatment	Initials