

Getting Started & General Help

Contact Us:

Forte Holdings, Inc

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Welcome and thank you for investing in ForteEMR for your practice!

After years of working with your industry we learned that the systems on the market just didn't offer the things that you needed. Because of that we invested in building *ForteEMR* and providing a great system that works for virtually any chiropractic office.

We engineered a travel card patient chart that not only shows you a great picture of your patients' progress, but is also super easy to use. The reports/soap notes can be printed anytime you need them. With ForteEMR we combine patient history, patient flow, patient notes and office chat to keep your office moving quickly.

This getting started guide will help you become familiar with the many great features in *ForteEMR*. Some of those great features you will learn about are:

- Patient History Check-in
- Patient Daily Check-in
- Patient Tracking
- In-office Chat
- Travel Card View (patient chart)
- Report generator
- Auto-Checkout
- To Do List

Our team will help you implement and learn the system and we will ensure your system is working as promised. We encourage feedback about the system and will work hard to incorporate the needed features into the system. Please send any ideas to sales@forteEMR.com.

We look forward to servicing your practice.

Thank you,

Forte Holdings, Inc
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Phone: 800-456-2622

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Getting Started

Installing *ForteEMR!!*

Note: FORTE EMR *requires a custom installation*. Please contact us to schedule a time to get the software installed.

Logging into *ForteEMR*

Begin by double-clicking on your *ForteEMR* icon on your desktop.



Next, enter your username and password to the system. If you have not yet setup a username and password, use the default username and password. They are as follows:

Username= user1

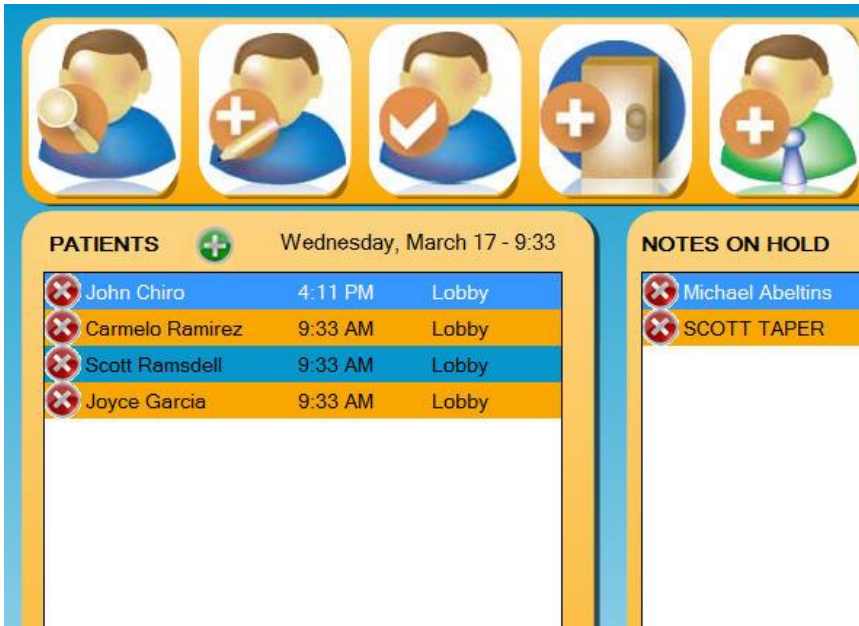
Password= test

A screenshot of a Windows-style login dialog box titled "Login". It has a blue background and standard window controls (minimize, maximize, close) in the top right. There are two text input fields: "User Name" containing "user1" and "Password" containing "****". Below the fields are two buttons: "Log In" and "Cancel".

Next, click LOG IN. The system takes about a minute to load the first time you open it for the first time each day. While your system is loading, you should see a splash screen that looks like one pictured on the right-side.

Once the system has loaded you should see your main screen, similar to picture below:





****Any action that is done in the Tools/options or Edit Options window, should be done from the SERVER computer to ensure best results.**

Adding your practice information to the system

When you log into the system for the first time, you need to customize your practice information.

To do this, go to **tools, options**. Then under the first tab (clinic information) input your clinic's information. Please complete all of the information- as this is used for your report headings.

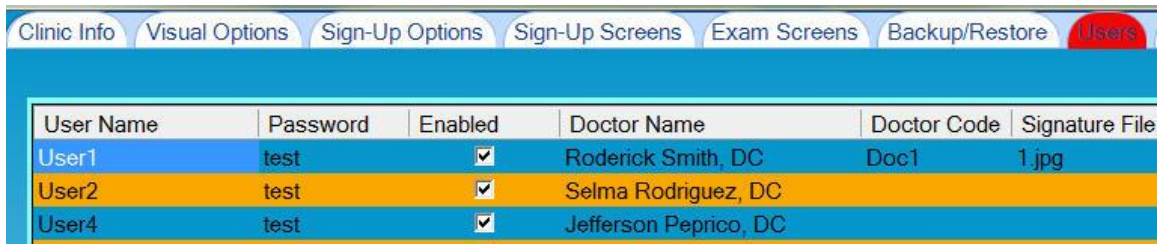
Business Name:	<input type="text" value="Wellness Chiropractic"/>
Doctor:	<input type="text" value="Micael H. Smith, DC"/>
Address 1:	<input type="text" value="1515 Chiro Ave"/>
Address 2:	<input type="text"/>
City:	<input type="text" value="Chiroville"/>
State:	<input type="text" value="CALIFORNIA"/>
Zip:	<input type="text" value="99999"/>
Phone:	<input type="text" value="515-555-5555"/>
Fax:	<input type="text"/>

To insert your own logo above the clinic information, just hit the pick square at the end of the bottom line called Reports Header Image and choose the logo from your computer.

Adding your information to the system (username, password and name)

When you log into the system for the first time, you need to customize your information.

To do this, go to **tools, options**. Then under tab (Users)
Then click on the line below the system users (user1 and user2).



User Name	Password	Enabled	Doctor Name	Doctor Code	Signature File
User1	test	<input checked="" type="checkbox"/>	Roderick Smith, DC	Doc1	1.jpg
User2	test	<input checked="" type="checkbox"/>	Selma Rodriguez, DC		
User4	test	<input checked="" type="checkbox"/>	Jefferson Peprico, DC		

Enter your preferred username, password and then enter your name as you wish it to appear on patient notes. Set the color you'd like for each doctor's patients to be in the check-in list.

Repeat process for all of your users in the practice making sure to have a doctor's name in the Doctor Name column. When finished, simply save and close out of options. The new users can be used the next time you open ForteEMR.

Security

To secure the software you may now require a password to make changes. Just choose Limited Staff in the User Type column of the User tab.

For security purposes, you may now quickly log out and back in with your own user name. Just go to the top left tab on the main page, File, then choose Log Out. Log back in quickly with your own passwords.

To choose the amount of security, you may use the following:

Admin = can do everything

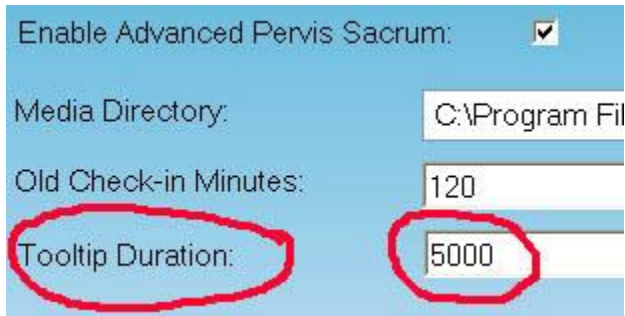
Power user/Doctor = can do everything except the administrative section where user accts are stored

Staff = can enter patient data and print reports but can't modify any options or delete data

Limited Staff/ Front desk = can use main window but can't access charts.

Customizable Pop-up Window time:

Now you can customize the number of seconds for the pop-ups. This would need to be modified options (tools/options/misc “tooltip duration”). Then you can set the number of seconds.



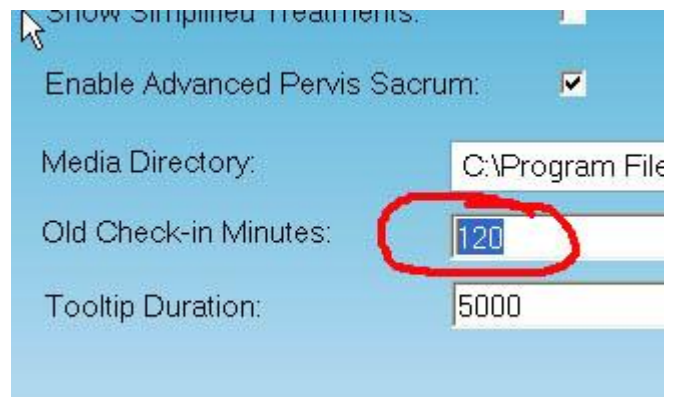
Note: Tooltips are the popup windows in the patient chart section. We had many requests to have these stay open longer. Now you can have them stay open as long as you would like!

Change color of patient after specific time period has passed:

If a patient has been on the check-in screen for a given period of time, the color will change to RED indicating they are an “old note” that needs to be finished.

Simply set the number of minutes you would like the system to use before changing the patient to RED on the main screen.

To modify this time, go to options (tools/options/misc “Old Check-in Minutes”). Then you can set the number of minutes the system will use to change patient to RED.



Patient Check-in

With ForteEMR, patients may complete a full medical history and subjective complaint history the very first visit- thus reducing the paperwork.

To begin with a patient enters their name and other demographic information as well as chooses a username/password for the system. This is important, because as they return for care they will use

this username/password to check-in and update their subjective (yes- they can easily add a new complaint).



Note: Patient Check-in questions can be slightly modified by going to your OPTIONS. To do this, go to **Tools > Options** and click on the “Sign up screens” TAB. For more information on customizing, please see customizing section towards bottom of help file.

New patient check-in

Please enter your personal information below:

First Name	Alex
Middle Name	J
Last Name	Niswander
Address 1	2110 County Cove Lane
Address 2	
City	Altoona
State	IOWA
Zip	50009
Home Phone	515-979-1195
Work Phone	515-979-1195
Cell Phone	515-979-1195
Email	alex@midwestsoftsolutions.com
SSN	454-54-5654
Occupation	IT
Please create User Name	janiswander
Password	*****
Retype Password	*****
Security Question	My mother's maiden name
Security Answer	bitcher

Gender Selection: Male (selected), Female

Date of Birth: 06/10/1970

Your user name and password will be used to sign in for your future visits. Please also enter security question and answer in case you forget your password.

Back Show Onscreen Keyboard Next

To launch the new patient process, first you (or patient) should click the button for new patient: “New Patients Click Here!”

Then the patient needs to fully complete the demographic data as shown above. It is easiest to ask them to complete all of it. Included in this screen is a field for Username and Password. They can use whatever they want, although your office may choose to have all patients use a specific format (such as first initial, last name like jchiro for John Chiro).

They also need to select Male or Female as well as enter their Date of Birth. Then they may select NEXT at the bottom right-hand side to proceed.

Note: Most screens during the patient check-in process will include a place for them to choose the OTHER box and type in anything they wish.

Now they click any allergies and choose **NEXT** to continue.

Next, they choose any past medical problems they have had and click **NEXT** to continue.

Then any surgeries may be selected and they again choose **NEXT** to continue. Patients can note family history here. Then they choose **NEXT** to continue.

Now, they choose any medications they are currently taking and click **NEXT** to continue.

Next, they choose the complaints they have and click **NEXT** to continue.

Now the patient is asked specific questions about each complaint. We are only displaying them once for example purposes, however they will have the same questions asked for each complaint they select beforehand. Then they click **NEXT** to continue.

The first screen covers:

- Date of onset
- Any notes about symptoms
- How symptoms are changing
- Similar symptoms in the past

Next, they describe the nature of their symptoms and click **NEXT** to continue.

Then, they describe how often they are experiencing their symptoms and click **NEXT** to continue.

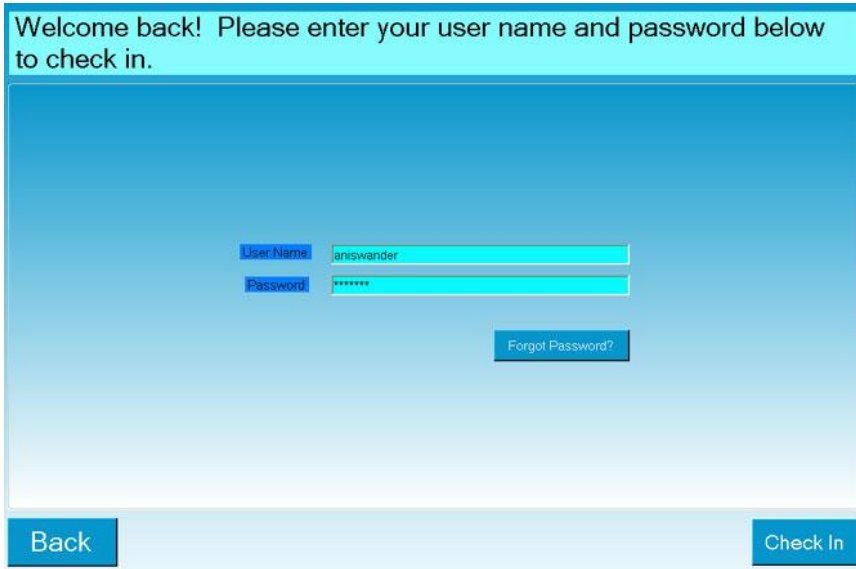
Next, they describe the nature of their symptoms and click **NEXT** to continue.

Now, we ask what they have tried that makes pain better and then they click **NEXT** to continue.

Now, we ask what activities make the pain worse and then they click **NEXT** to continue.

Last, we ask what they hope to gain from our treatments and they click **NEXT** to finish.

Existing patient check-in



Welcome back! Please enter your user name and password below to check in.

User Name: aniswander

Password: *****

[Forgot Password?](#)

[Back](#) [Check In](#)

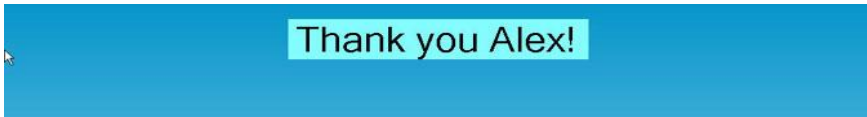
To launch the existing patient process, first you (or patient) should click the button for existing patients: “Existing Patients Click Here!”

Then the patient needs to enter their previously chosen Username and Password to login. Next the system will ask some questions about each of their complaints. The patient is checked into the system and the subjective information completed is transferred directly to their chart and included in the soap note.

First, we ask a general how are you feeling question and they click **NEXT** to continue.

Then, we ask patients to rate each complaint on a 1-10 pain scale and they click **NEXT** to continue.

Last, patients are asked if they have a new complaint and then are directed to click **NEXT** to finish.



Thank you Alex!

The last screen will display to indicate they have completed the check-in and should be seated until they are called by a staff member.

Auto-accident check-in

During our normal ‘new patient check-in, a patient may indicate this is an Auto Accident, the system will then guide them through the check-in and ask them auto accident related questions.

The patient will be prompted to complete a series of screens regarding their accident such as:

Road conditions, vehicle damage, patient injuries, and so on.

Next the patient will be guided through screens relating to any pain they are now experiencing. These screens are not shown here, but are the same as the complaint screens in the patient check-in section above for non-auto.

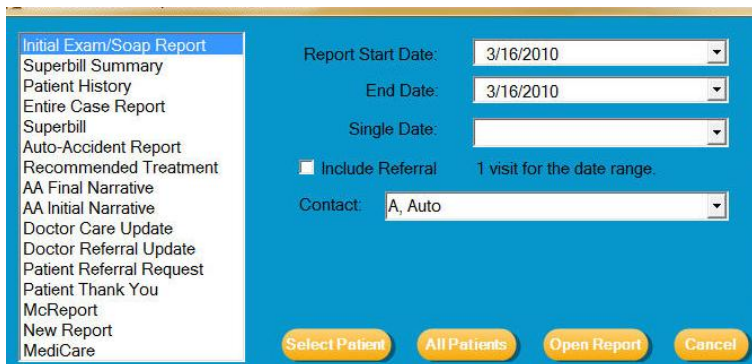
Now the patient is finished with the auto accident check-in and you may want to review all that the patient completed. To view a completed auto-accident report, do the following:

First, open the patient chart (travelcard) screen for the patient.

Then, click **REPORTS** in the top right-hand section of their patient chart (travelcard) screen.



Now the reports window opens and you need to select the Auto-Accident Report and click OPEN REPORT in the bottom right-hand corner.



If you are not using the Kiosk: you will go to the patient’s chart and scroll down to the section called “Auto Accident”. On the current date, click into that section and you will get a screen like the one below.

Auto Accident: Sue Tom

Accident Date: Opposing Vehicle Speed:
 Driving Role: Vehicle Speed:
 Vehicle Status: Headrest Position:
 Impact Area: Admitted:
 Lighting Conditions: Admission Time:
 Road Conditions: Transportation To Hospital:
 Visibility: Doctor:
 Opposing Vehicle Type: Hospitalized Days:
 Bracing Status:

Problems

Brightness Darkness Fog Rain Snow Traffic

Injury Locations

Back of Face Back of Head Back of Neck Chest Fingers on Left Hand Fingers on Right Hand
 Forehead Front of Face Front of Head Front of Neck Left Arm Left Elbow
 Left Hand Left Hip Left Knee Left Leg Left Shin Left Shoulder
 Left Wrist Low Back Mid Back Nose Right Arm Right Elbow
 Right Hand Right Hip Right Knee Right Leg Right Shin Right Shoulder
 Right Wrist Side of Face Side of Head Side of Neck Upper Back

Multiple Auto Accident Cases – You will need a new Auto Accident case separate from their original case so you will have to open their existing chart and click on Add New Case at the top of their chart. Type in Auto Accident #2 or the desired name you want to call it and then scroll down to the Auto Accident portion of their chart and double left click into today’s section to open up the Auto Accident questions. Fill out the chart using the drop downs and Save and this will now be a new separate case for this patient.

Main Screen - Overview

The main screen overview features a row of five patient icons at the top. Below this is a 'PATIENTS' section with a green plus icon and a time filter for 'Wednesday, March 17 - 9:33'. A table lists four patients with red 'X' icons in the first column:

Icon	Name	Time	Location
	John Chiro	4:11 PM	Lobby
	Carmelo Ramirez	9:33 AM	Lobby
	Scott Ramsdell	9:33 AM	Lobby
	Joyce Garcia	9:33 AM	Lobby

To the right is a 'NOTES ON H' section with two entries, each with a red 'X' icon:

- Michael Ab
- SCOTT TA

The main screen consists of your most valuable resource for managing patients as they move through your practice. If you use the Patient Check-IN, those patients who have checked in, will be displayed in a list with the time of check-in displayed next to their name. You can also see which rooms patients are in, chat with co-workers, use a To-Do list, and manage contacts.

These items and more will be explained in detail below:

Patient flow

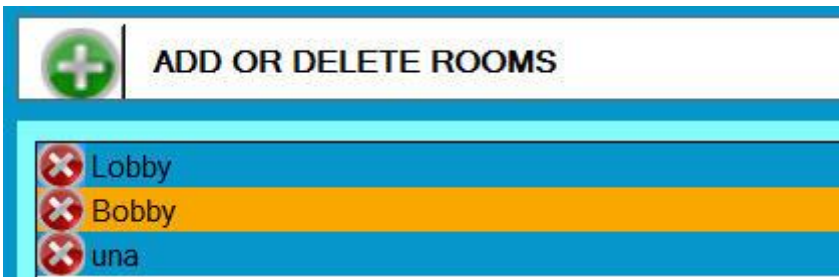
In our system patient flow simply means “management of the patients while they are in your office”. You can see from the picture above, it is easy to see which patients are already waiting in the office. You also see the time that they checked in. Above the patient list you will see today’s date and current time so that you can see how long your patients are waiting.

By default each patient is going to be stationed in the “lobby”. It is up to you to take a patient and move them to a room so that everyone in the office knows where that patient is located.

To do this, you simply right-click on the patient, go to rooms, and left-click the room you need. To modify the list of rooms, please see adding/editing rooms below.

Once a patient has been seen, and a note completed, they will automatically be removed from the check-in screen. Should you need to remove a patient manually, use the RED X that is to the left of the patient’s name.

Adding/editing rooms



To customize the list of rooms, first delete any rooms that you will not use. To do this, click the RED X to the left side of the room name. You won’t be able to do this if someone is currently in that room. Then you need to add your new rooms by clicking the yellow + sign next to the ‘add or delete rooms’ at the top of the window. Type the name of your room and click save. Continue the same process for as many rooms as you need added. You may also choose a color for each room. Lobby will continue to be default but you can click into the word and change it. To save you must click on a different room’s row and close the box. When you are finished, click CLOSE in the bottom right.

Adding/editing To-Do list

To customize the To Do list, click the green + sign next to the ‘To Do list’ title. Then type the name of your item and click save. Continue the same process for as many To Dos as you need added. To remove a To Do item when finished, click RED X next to the name of the item in the list.

CHATTING

The chat function works like any other chat room.

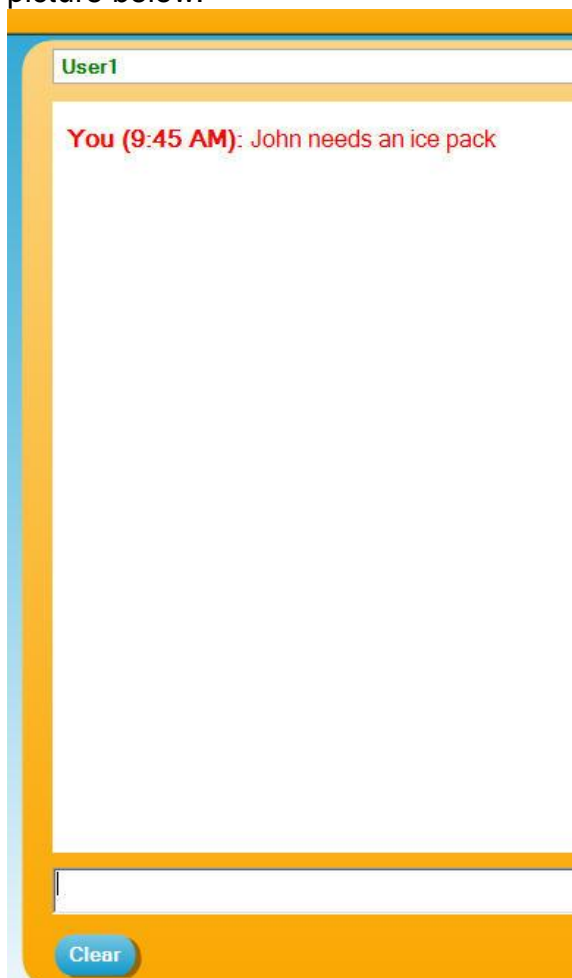
It's turned on and off by clicking the chat bubble in the row of icons at the top. (See picture below).

To send a message, simply select the desired recipient from the drop down list (it shows the green text) and then begin typing your message in the bottom white text box.

Once your message is ready, click SEND.

If you would like to send messages that everyone can see use the conference mode in the same drop-down list where you select the user. Then have everyone else also ensure they have conference as the drop-down name. You must be on same frequencies to see each other.

If you are not seeing chat message, you need to click the BLUE chat bubble icon as show in the picture below:

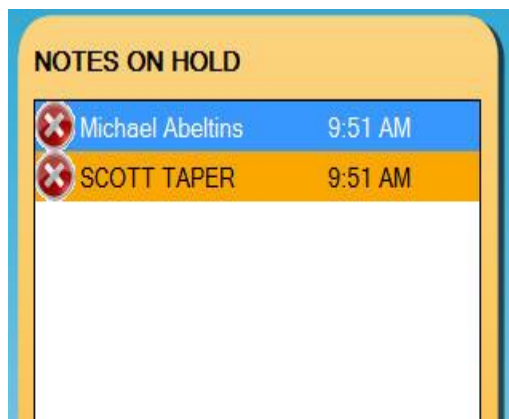


Clear Chat Screen Button:

There is a button to clear the previous chat entries on your screen. **WARNING:** Each day will clear automatically at the end of the day, so if there is something you want to be saved overnight, it may be better suited for the ToDo list.

Notes On Hold:

You may now use the "on hold" to send people whose notes are not finished or have something left to be completed. You can do this with a right click over their name in the rooms, or from the drop down on their patient chart.



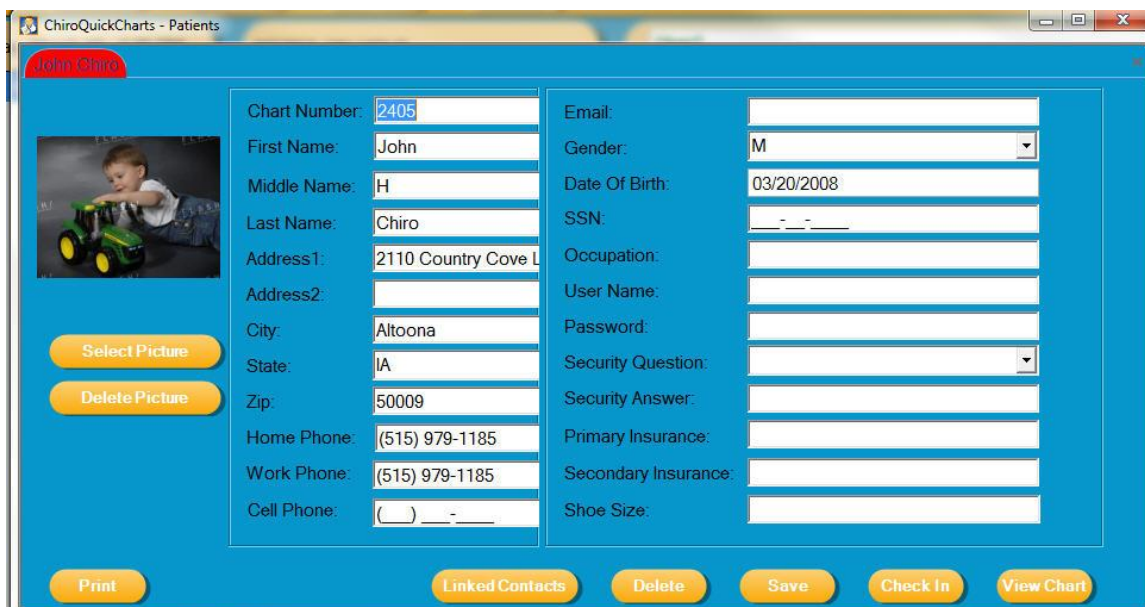
Adding patients



You may add new patients by using the ADD PATIENT button from the main screen (as shown above).

If you want to add a picture, first add the data (name, address, etc) and then click SAVE. Once you have clicked save, you may then use the SELECT PICTURE button and browse for a picture on your computer, or your server.

Print out the patient information using the print button in the bottom left corner.



The screenshot shows a web application window titled "ChiroQuickCharts - Patients" with a patient profile for "John Chiro". The form contains the following fields:

Chart Number:	2405	Email:	
First Name:	John	Gender:	M
Middle Name:	H	Date Of Birth:	03/20/2008
Last Name:	Chiro	SSN:	__-__-__
Address1:	2110 Country Cove L	Occupation:	
Address2:		User Name:	
City:	Altoona	Password:	
State:	IA	Security Question:	
Zip:	50009	Security Answer:	
Home Phone:	(515) 979-1185	Primary Insurance:	
Work Phone:	(515) 979-1185	Secondary Insurance:	
Cell Phone:	() - -	Shoe Size:	

Buttons at the bottom of the form include: Print, Linked Contacts, Delete, Save, Check In, and View Chart. On the left side, there is a "Select Picture" button and a "Delete Picture" button next to a placeholder image of a child with a toy tractor.

Editing patients

To edit a patient's data, you may right-click on their name and click edit patient (as shown below).



If you want to add a picture, first add the data (name, address, etc) and then click SAVE. Once you have clicked save, you may then use the SELECT PICTURE button and browse for a picture on your computer or your server. Then, simply modify any of the data and remember to click SAVE before closing.

TIP: You can also edit their data from the find patient screen by using the right-click or edit patient button at bottom of find patient window.

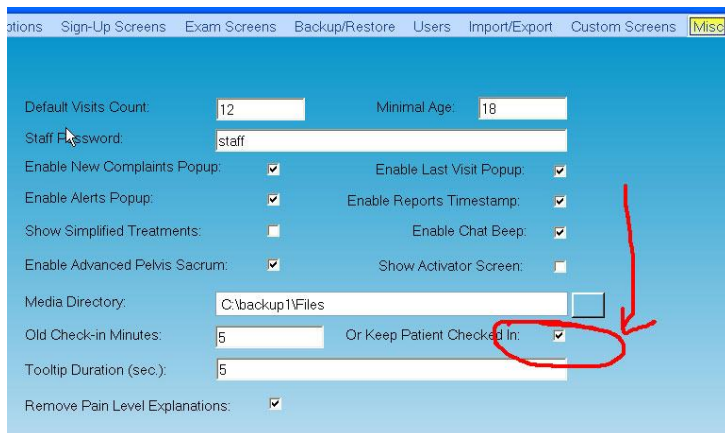
Checking-in patients

To check-in a patient manually, first open the find patient window and then type a portion of their last name. Once they are displayed in the list, simply right-click and click Check-In Patient. This will move the patient to the check-in list and you can close the find patient window. You'll get ALL patients when you type %. *You may now pop this window up from any part of QC by holding the Shift key and hitting the letter F.



Ability to keep patients checked in until you manually check them out:

First open your options (tools/options from main screen).
 Then select the MISC tab at very far right-hand corner of top tabs.
 Last, select the checkbox labeled “or keep patient checked in”.



Opening a patient chart

There are a number of ways to open a patient chart. The easiest way is to double-click their name in the check-in list (shown below) but you may also right click over them and open their chart or choose to go directly into their Exam/soap input screen.



If the patient is not listed in the check-in list, then you need to open the find patient (first icon top left in picture above) and type a portion of their last name. Once they are displayed, you can either right-click their name and choose view chart, or high-light their name and click the View Chart button at the bottom of the window.



View Only for Chart entry:

There is a view only option which allows you to open a chart from FIND PATIENT SCREEN without creating a new note for today. You are then able to modify an older visit by double-clicking any field under the older date. See the view only option in find patient pictured above.

Adding a contact (Attorney/Referring Doctor) to the system

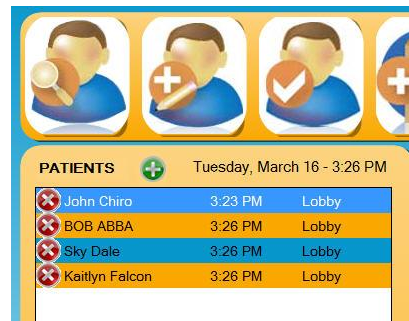
You may want to add contact to your system such as an attorney or referring doctor. To do this, click the contact icon on your main screen (shown below).



Then you need to click the New Contact button at the bottom of the window.

First Name	Last Name	C	Title	Home Phone	Work Phone	Cell Phone

Next you need to input the contact's information and click SAVE before you close the window.



Removing a patient from check-in list

If you need to remove a patient from the check-in list, click the RED X to the left of the patient's name in the list. This will remove the patient.

Patient Chart

Chart Overview

The screenshot shows a patient chart for John Chiro, case 00001234. The interface includes a search bar, a main menu, and a central table of visit data. The table has columns for dates (8/26/2010, 11/1/2010, 1/25/2011) and rows for various categories: Visit Type, Doctor, Complaints, Palpation, ADJ / TX, Treatment, Diagnosis, Patient History, Plan, Assessment, Posture, Prognosis, Notes, and ROM. To the right of the table is a 'Patient Files' section with thumbnails for anatomical diagrams and medical images like X-rays.

	8/26/2010	11/1/2010	1/25/2011
Visit Type	Exam	Followup Visit	Followup Visit
Doctor	Tim Thompson, DC	Tim Thompson, DC	Tim Thompson, DC
Complaints	Headaches - 6 Neck Pain - 5	Headaches - 5 Neck Pain - 5	Headaches - 5 Neck Pain - 5
Palpation	Tenderness was found in left T5-6, L3-4, hip, right C1-2..	Subluxation, swelling was found in left C1-2, T3-4, L2-3.	Subluxation, swelling was found in left C1-2, T3-4, L2-3.
ADJ / TX	Adjusted left T5, L3 and hip, right C1	Adjusted left C1-2, T3-4 and L2-3 with Diversified technique	Adjusted left C1-2, T3-4 and L2-3 with Diversified technique.
Treatment	CMT 1-2 Spinal Regions (98940) - Lumbar subluxation (839.20), - Dizziness, vertigo (780.4), -	CMT 1-2 Spinal Regions (98940) - Lumbar subluxation (839.20), - Dizziness, vertigo (780.4), -	CMT 1-2 Spinal Regions (98940) - Lumbar subluxation (839.20), - Dizziness, vertigo (780.4), -
Diagnosis	Lumbar subluxation (839.20), Dizziness, vertigo (780.4), Headache (784.0) and Neck pain (723.1)	Lumbar subluxation (839.20), Dizziness, vertigo (780.4), Headache (784.0) and Neck pain (723.1)	Lumbar subluxation (839.20), Dizziness, vertigo (780.4), Headache (784.0) and Neck pain (723.1)
Patient History	Allergies: Animals, Molds, Penicillin, Ragweed/Pollen, Soaps Surgeries: Disc, Neurological, Disc in	Allergies: Animals, Molds, Penicillin, Ragweed/Pollen, Soaps Surgeries: Disc, Neurological, Disc in	Allergies: Animals, Molds, Penicillin, Ragweed/Pollen, Soaps Surgeries: Disc, Neurological, Disc in
Plan	Spinal manipulation 2x times per week for 3 weeks. Modality/Therapy: Hot packs -	Spinal manipulation 2x times per week for 3 weeks. Modality/Therapy: Hot packs -	Spinal manipulation 2x times per week for 3 weeks. Modality/Therapy: Hot packs -
Assessment	After today's assessment condition is progressing slow, but steady.	After today's assessment condition is progressing slow, but steady.	After today's assessment condition is progressing slow, but steady.
Posture	Apparent Lumbar Curvature(R), Elevated Iliac Crest(L), Elevated Shoulder(L)	Apparent Lumbar Curvature(R), Elevated Iliac Crest(L), Elevated Shoulder(L)	Apparent Lumbar Curvature(R), Elevated Iliac Crest(L), Elevated Shoulder(L)
Prognosis	At this time Patient's prognosis is fair.	At this time Patient's prognosis is fair.	At this time Patient's prognosis is fair.
Notes			
ROM	Cervical ROM: Flexion ROM is 45/50. Pain: significant. Pain level: 0. Left Lateral Flexion	Cervical ROM: Flexion ROM is 45/50. Pain: significant. Pain level: 0. Left Lateral Flexion	Cervical ROM: Flexion ROM is 45/50. Pain: significant. Pain level: 0. Left Lateral Flexion

Using the TOP of the Chart

Alerts

Using an alert is very easy. If you would like to add an alert for a patient, you need to double-click on the alerts heading and then type in the alert.

Notes

The white box below alerts is where you can type notes about the patient that you feel are important. This is pretty straight-forward. Simply click in the white box and begin typing.

Number of Visits

The number of visits is a note counter that begins with the patient's first visit and automatically increments with each note completed. The default number of visits is 12, although you may change this in OPTIONS and if you want to change for just a single patient, simply double click on the number of visits and modify the 12 to whatever number you want.

Re-Exam Date

The re-exam date is a calendar you may wish to use to select the approximate date of their re-exam. To select a date you must click the down arrow and click the date you wish.

Problem List

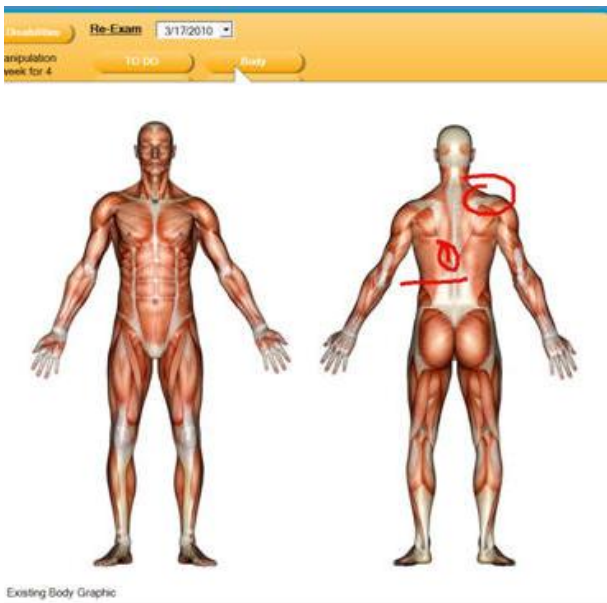
You may access an up to date problem list from the patient's chart. Click into the various fields or use the drop-down to make entries. Click the square at the end to choose from the most recent DX you have for this patient. You have a choice of All, Past, or Current.

Handouts

ForteEMR includes over 30 handouts regarding chiropractic care. To print a handout, first click the handout button and then select the desired handout from the list and click PRINT. This will create the handout in a report viewer (soon to be word) where you can print or save to your computer. The report will then be highlighted and dated in that person's chart so that you know it's been given to them. We've also added the patient's name at the top to personalize them. You may email handouts to patients whom you have entered email address into their Edit Patient. Just choose the handout and hit the Email button at the bottom of the Handouts popup.

Popup picture of body graphic:

If you have a body graphic for the current patient and it has been "inked on", when you hold your mouse over the body button, you will get a pop-up box like the one below:



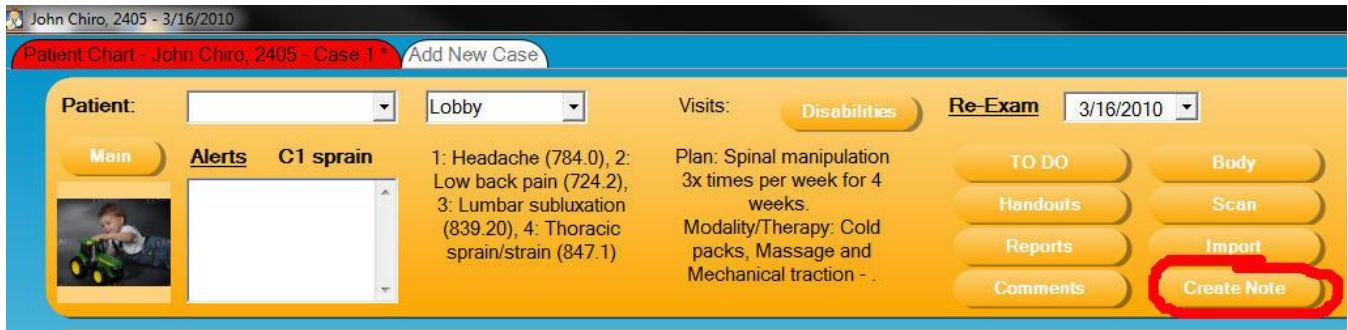
Create Note:

If there is not a visit created and you need one for today (or for back-dating) simply click the CREATE NOTE button to have a new visit created.

Creating a new patient NOTE:

1. If you are creating a note for today for a patient, simply open the patient chart and a new note will be created (provided the patient was just put on the list today).

- If you are creating more than 1 note at a time, follow step 1 and then double-click on the date at top of column and change the date to needed date. Then you need to click the CREATE NOTE button at top right-hand corner of patient chart.



Scanning

To scan into a patient's chart, first connect your scanner to the PC you will be using to scan from (this is typically a USB cable). Ensure that your scanner has power and that the scanning software has already been installed on this PC.

Next, open the patient's chart and click the SCAN button. This should launch your scanning software and you need to scan the item using the scanners software. Once completed you should be given the opportunity to name and save the file.

(Scanning & Importing Buttons)



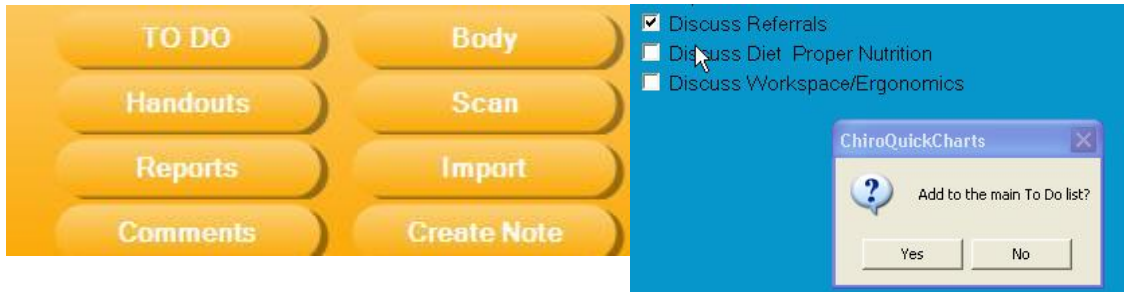
When you finish you should see files/images on the right side of your chart. To open the files after scanning or importing, simply double-click the file.

Importing Files

To import files into a patient's chart, first open the patient's chart. Then click the IMPORT button (as shown below).

Next, browse to the location of the file/s you are looking for. Once you find the file you want, double-click on the file and click OPEN. You will be prompted to give the file a new name and then click OK.

ToDo list in patient chart can also display on main screen:



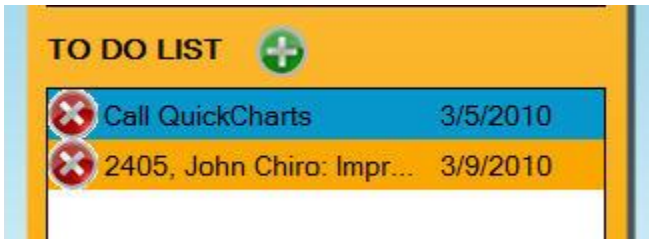
When you choose an item that already exists from the ToDo list, it will create a pop up that allows you to set it to pop up for you on a certain date or a given number of visits later. This keeps you from forgetting to do important things with the patients. The button with turn a different color is there is something checked in the list.

When you add a ToDo list item from patient chart, it will ask you if you also want this to be added to your ToDo list on the main screen. You may clear these items from the Main screen or from within the pop up in the patient chart.

Once you have an item on the Main ToDo list, you can double click on that person's name and that item will pop up to be modified if needed. By dragging and dropping a patient from the check in list to the ToDo list, you will be able to access their ToDo list from the Main page as well.

You will also be able to edit options right from the top left corner of the ToDo pop up. Just click it and make the additions/changes necessary. Save it and changes will appear when you close and come back into Quick Charts.

The ToDo (Checklist) can also be found above the buttons in the Exam Screen under the word "Other". It works the same way it does in the patient's chart.



Reminders

To set a reminder for a specific patient to pop up at a certain visit count or a certain date, add the reminder to the ToDo list. Put a check mark next to it and there will be a pop up to fill out as to when you want the reminder to pop up in that patient's chart when you open it.

Disabilities Testing

To fill out a disabilities test on the spot, go into the patient's chart and click the DB button. Choose the proper test from the drop down. Click Take Now and then either allow them to answer the questions on your computer or ask the questions and click the response for them. When the test is complete, the window will close. To print or see the answers they chose simply click the DB button and then double click on the test at the bottom. You should see the score there as well and this will print on the Assessment section of their reports.

If you are using the kiosk and would like a certain test to pop up for them when the patient comes in and goes to the kiosk, you may set that schedule (one for each test that you want them to take) so that they will get it every 10th visit (or any other visit number). This has to be done AFTER their first visit since they will not have a chart until then.

Past visits (in the chart)

To view past visits you need to use the bottom scroll bar and scroll back to the left. This will store ALL of the visits after you have more than 3 visits/notes completed for the patient. Right click over any date and you may also choose the one you'd like to skip right back to.

Way to show a visit was cancelled or other note for correspondence:

You can now input a note if someone did not show up or if you want to note anything else and don't want to show up in the report.

BLUE + sign to add a new entry. Click ADD to save.

In your patient chart there is a new button labeled 'COMMENTS' in the top-right hand corner. Simply click the button and you can click the



Moving Patients from Room to Room

You may move them to a different room from the drop down seen in the top right corner of the chart. You may also do this from the drop down seen near the top/middle of each patient's chart.

Assigning a Doctor

You can now choose a doctor for each visit. It defaults to the top row in the patient's chart. Just double click over the doctor's name and your list of doctors will come from your User panel. Always make sure you only list DOCTORS in the column called Doctor Name in the user set up (Tools/options/users). Choose the doctor you want and move on to the exam/SOAP. If you use Medisoft or Eclipse you will also be asked to choose a doctor upon exporting.

Doing the exam/re-exam

Doing an exam in ForteEMR is a detailed process and requires practice, practice! Here are the steps for doing an exam and much of the same process is completed when you do a follow up visit (soap visit).

Once you complete your visit, the top bar will show items such as Diagnosis and Current PLAN.

Communicating with patients via email

To email all patients at once, open the find patient window (Icon with check mark) and choose the Email button at the bottom. Type the subject in the top line and the body below it. To send to everyone, just hit All Patients and send. To send to an individual, go to their Edit patient window.

Starting the Exam/SOAP

Double click the mouse's left side any where under the date you would like to complete. If you click in the palpation section, that's where you will end up. This is true for each section you click in. This makes it quicker for you to get directly to where you need to make changes/additions.

The exam/soap screen consists of many buttons on the left and then findings and tests on the right side. To complete the tests needed, simply find & click the button you need. Then you will need to select your findings.

To do the exam, first you need to open the exam window. Do this by double-clicking on any of the blue and light-blue lines under the current date heading. Keep in mind that which ever box you double-click in, you will go to the same box in the exam section. For example, if you double-click in the Diagnoses box, you will go to the diagnosis box in the exams screen (shown below).

How to do your exam/ input findings

Most findings are inputted the same way as we describe below:

First choose 1 or many findings and then select 1 or many areas affected. Most, but not all boxes will have a white preview box that shows you the final product of what you have selected.

In the example to the right, we are seeing our palpation exam. In this case, simply click the findings (such as swelling) and then click the area or region affected (such as cervical, lumbar).

The same steps can be followed for almost all exams. Refer below to detailed instructions for each type of exam we currently have in the system.

You can do the exam in which ever order you wish and you can also change the order of the exam buttons (to modify button layout, please refer to customizing section later in help file). You'll also notice that when you just look, as opposed to making a change in one of the windows, the buttons turn colors accordingly. This allows you to track where you've been and if you've changed something in that window.



Show items from the notes section in the preview text box:

Items you add in the bottom notes boxes will now display in the white preview boxes which are also located at bottom of screen.

Complaints

If you use our patient check-in module for history and complaints, then you may not use the complaint section. If you decide to input complaints then refer to the steps below.

First, click the COMPLAINTS button and the screen should look like the one below.

Click the check-box of the complaint you need to enter for this patient. This process is done for every complaint the patient has. Once you click a check-box, another window is opened allowing you to input more information about that complaint.

Next you need to enter the items such as:

- When it started (fill out the date or time frame)
- Improvement (better, same, worse)
- Intensity (mild, moderate, severe)
- Nature (sharp, shooting, dull)
- What decreases pain(ice, heat, etc)
- Pain level (pain scale 1-10)
- Activity affected (1-10 scale)
- Frequency (how often)
- ADLs (bottom button shown below)

Repeat the same process for as many complaints as needed.

NOTE: To remove a complaint you un-check the check-box. You will get a warning message asking if you are sure, so be sure before you delete- this cannot be undone!

Templates

To build a template for common problems that people tend to get treated for, (ex. cervical sprain/strain) you can save all of the items that you input for their treatment and use it again on the next person that has that same problem. Just fill in all of the windows to create the note, and then go to “Other” just above the top button, and choose Save As Template. Name it Cervical Sprain/strain, or whatever you are treating, and on the next patient you treat for this problem you can click Other, Next, and choose Apply Template and the applicable template name.

Subjective

This new button will pop up a window that allows you to input certain phrases quickly. Example: This patient indicates that subsequent to our last treatment they experienced reductions in symptomatology occurring as anticipated. This patient indicates that subsequent to our last treatment they experienced no significant changes in ability to perform activities of daily living and recreation since the time of our last visit. Symptomatology is best upon rising.

We’ve also add a right click to get to the Subjective sentences, ADLs, and Assessment per complaint to make it quicker for you. Just right click anywhere in the complaint window.

Editing ADLs

Now you can edit the activities of daily living from the top left corner of the pop up. Just click on edit options. Make the changes, save, and when you close and come back into QC you will see the changes.

When a patient is checking into the system, they can specify with a CHECK BOX as to which side their pain is on. This also applies to the complaints screen inside of the patient exam screen, inside the patient chart grid. You will also see a C for central and N for none.

Here is how the screen looks from the exam/patient chart point of view:

The screenshot shows a software interface for recording patient complaints. At the top, there are three tabs: 'Complaints', 'Headaches', and 'Neck Pain'. Below the tabs, there are two input fields: 'Condition Started' and 'Condition Start Details'. To the right of these fields is a 'Side' selection area with three radio buttons labeled 'L', 'R', and 'B'. The 'B' button is selected and highlighted in red. Below the 'Condition Started' field is a checkbox labeled 'Not Sure When Started'. At the bottom, there is a 'Pain Level' section with a horizontal row of radio buttons numbered from 0 to 10, plus a 'None' option. The radio button for '8' is selected and highlighted in red.

Diagnosis

The diagnosis is very easy to use. To begin with you have a common list of diagnosis codes, which is located in the first diagnosis box that opens. To modify your common list you need to EDIT OPTIONS and there is a small check-box next to the diagnosis that allows you to make that diagnosis code a common entry.

To select a diagnosis for a patient, you just need to select the check-box next to the diagnosis name.

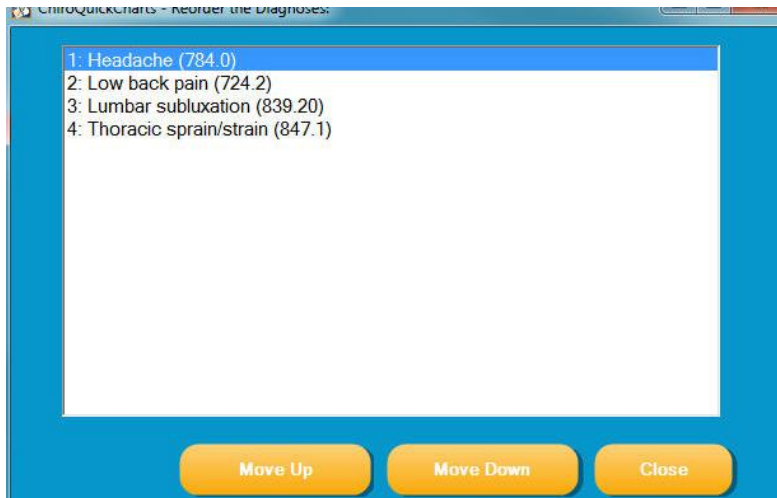
The screenshot shows a list of diagnosis codes under the 'Common' tab. The list includes: Backache (724.5), Cervical radiculitis (723.4), Cervical rib (756.2), Cervical sprain and strain/whiplash injury (847.0), Cervical sprain/strain (847.0), Cervicalgia (723.1), Headache (784.0), Low back pain (724.2), Lumbar facet syndrome (724.8), Lumbar subluxation (839.20), Lumbosacral radiculitis (724.4), Neck pain (723.1), Sacroiliac sprain/strain (846.1), Tension headaches (307.81), Thoracic sprain/strain (847.1), and Thoracic subluxation (739.2). The 'Headache (784.0)', 'Low back pain (724.2)', 'Lumbar subluxation (839.20)', and 'Thoracic sprain/strain (847.1)' items have their checkboxes checked and are highlighted in red.

If you need to use a non-common code, simply click the name of the area the code applies to and then you should easily find the code. Should you need to add a code to the list, you need to EDIT OPTIONS and add the code (see customizing section below for specific instructions).

You may now add an entry by clicking on the + sign at the bottom of each section and you can add an entirely new tab to the top by going to Edit Options, Exam Screens, and scroll down to Diagnosis Categories in the white scroll area.

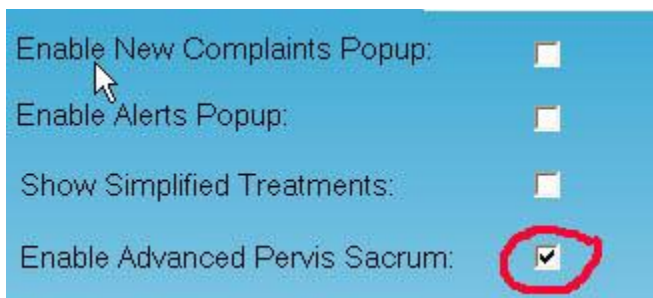
Set the order of your Diagnosis Codes:

When you select a diagnosis code you will no longer get a popup box. Instead you'll have a button called "Reorder" at the bottom of that screen. If you would like to change the order of your diagnoses you will click on that button and then make changes by highlighting and moving up or down. You may also click on them in the order you would like them.

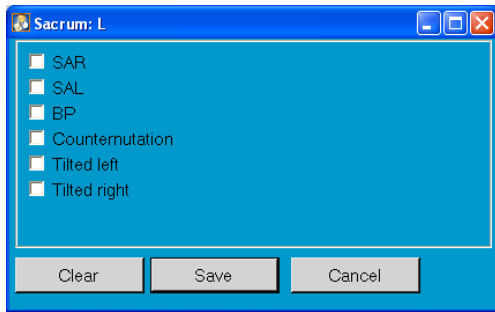


Customizable Listings for the Pelvic/Sacrum:

Now you have an option to enable a pelvic/sacrum customizable list of choices. Then you can add whichever listing you would like. First you need to enable the new feature in options (tools/options/misc "enable advanced pelvic/sacrum").



This is what you'll see when you use the pelvic or sacrum button in adjustments.



Palpation (Spinal & Muscle findings)

To complete spinal/extremity palpatory findings, first click the check-box (or many check-boxes) located under the condition heading. Then choose the affected areas. They turn to red to show what was completed. If you clicked one by mistake, then you may click again to de-select it.

Palpatory findings roll over to future visits to save you time. In that event, if you need to start over, simply click the CLEAR button and start over.

For muscle findings, you must select LEFT, RIGHT or BILATERAL before selecting the muscles.

You'll see buttons with C, T, and L on them here. These are for the cervical, thoracic and lumbar regions. You'll also notice CT, TL, and LS. These are for combinations of cervical/thoracic, thoracic/lumbar, and lumbar/sacral. Cranial and Sub-occipital have also been added and TMJ (Temporal Mandibular Joints) are now listed in the fourth column as well

Condition

Asymmetry Edema Stiffness Hypertonicity Restricted motion Muscle spasm
 Loss of strength Subluxation Swelling Paraspinal edema Tenderness

Cer			Tho			Lum			L			B			R			RIBS		
CT	TL	LS	T1	T1	T1	L1	L1	L1	SI	SI	SI									
Cranial			T2	T2	T2	L2	L2	L2	sacrum	sacrum	sacrum				1	1	1			
Sub-occipital			T3	T3	T3	L3	L3	L3	pelvis	pelvis	pelvis				2	2	2			
L			T4	T4	T4	L4	L4	L4	hip	hip	hip				3	3	3			
Occ			T5	T5	T5	L5	L5	L5	knee	knee	knee				4	4	4			
C1	C1	C1	T6	T6	T6				ankle	ankle	ankle				5	5	5			
C2	C2	C2	T7	T7	T7	S1	S1	S1	shoulder	shoulder	shoulder				6	6	6			
C3	C3	C3	T8	T8	T8	S2	S2	S2	elbow	elbow	elbow				7	7	7			
C4	C4	C4	T9	T9	T9				wrist	wrist	wrist				8	8	8			
C5	C5	C5	T10	T10	T10	TMJ	TMJ		hand	hand	hand				9	9	9			
C6	C6	C6	T11	T11	T11				foot	foot	foot				10	10	10			
C7	C7	C7	T12	T12	T12										11	11	11			
															12	12	12			

Intensity

Mild Moderate Severe None

Weakness, loss of strength was found in left C1-2, T3-4, L3-4.

Delete Selections Clear Undo Transfer Notes

You may also choose pain ratings from mild to severe. These are found below the extremities as seen in the screenshot above. You will also get a pop up for **where the pain is radiating** to when you choose a muscle under the muscle tab. Click ENTER for a quick way to close the pop up if you don't want to use it. You will also see a transfer (at bottom) of levels from the Palpation window here. This sends the same segments you palpated, to the Adjustment window so you won't have to click them again over there.

To **grade the palpation** 1 – 10, right click on the preview sentence at the bottom.

If you clear something by mistake, you have an **UNDO button** that can be used. This does not work in the case of deleting something or using the new CLEAR ALL in the complaints section. This is simply for exam/palpation/etc and if you happen to clear by mistake, you can use the UNDO to return to the last entry.

We now have an **ART** tab on this page. There you'll find muscles grouped together so you can easily choose an entire group. Just choose a condition and the muscles to go with it. Choose the + sign to see the muscles included in that group.

Adjustments/ Treatments & Rehab

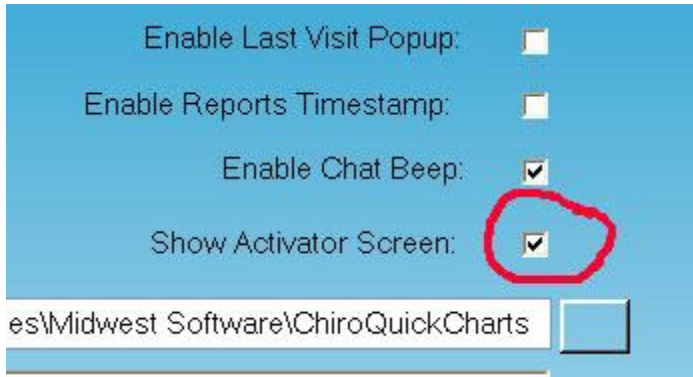
To complete your areas adjusted, first click the adjusted areas. They turn to red to show what was completed. If you clicked one by mistake, then you may click again to un-select it. If you transferred them from the palpation, you may either add the technique or choose Add Entry to start a different adjustment. If you forgot to transfer from palpation you can pull it over using the transfer button at the bottom.

Once you have your areas selected, you then need to select your type of adjustment technique used (such as activator or diversified).

Adjustments roll over to future visits to save you time. In that event, if you need to start over, simply click the CLEAR button and start over.

Activator Adjustment Listings:

Now you can use several adjustment screens at once for adjusting. They would need to be enabled in options (tools/options/misc "show activator screen"). You may turn on the Activator, Activator w/extremities, Gonstead listings, Simplified Treatments, and Adjustments, and Treatments (treatment/procedures, TX).



Once you've made the checks in the boxes of the screens you would like to use, you need to close and re-open ForteEMR to see the added screens once you open a patient chart and open today's visit.

Treatments

Treatments are inputted by first selecting the treatment tab at the top of the window and then clicking the treatments performed.

If you do not have Simplified Tx enabled in the Misc tab of Options (which we recommend) you must click the ADD ENTRY button to start and use it in between each tx as well. This is a very important step. If you forget the ADD ENTRY button, your entry will not be added. If your treatment requires an area, or number of minutes, you will see the selection appear when you select that bulleted item. Once you input the number of minutes or the area the therapy was applied to, choose save.

To take items off or change minutes/units, simply uncheck the item and remove or modify. To export charges, click the Export button. It will change colors if export is complete.

If you have entered codes in the parenthesis for the x-rays, equipment, or supplies, if you have chosen them in their respective windows they will pop up when you hit the export button so you may choose to export them as well.

Rehab

Rehab is as simple as it looks. Click the tab at the top and then click the check-box of the rehab you performed. You may add new items to your list (refer to customizing section below).

Assessment & Prognosis

Assessment and prognosis are set by clicking the check box/es of the item/s you wish to select. You may also add items to the assessment tab by using the + sign at the bottom of the box.

Plan

Your plan section consists of many items: Plan, Home Therapies, and Goals & Patient Responsibilities. All of which can be customized by you. To use the actual plan section, click the item you need under the PLANS heading (such as spinal manipulation). Then click the count and frequency (such as 2X, week) then select the duration (such as 3 weeks). You can also choose minutes.

Some items such as therapies will cause the list of therapies to appear. Then you need to select which therapy you plan to do. You may now add a new item to the Plan section by clicking the + sign and typing it in and clicking ADD.

Count:	1x	2x	3x	4x	5
Frequency:	Hour	Day	Week	Month	
Time:	15min	20min	30min	45min	60r
Duration:	1	2	3	4	5
		Day	Week	Month	

Spinal manipulation 3x times per week for 4 weeks
 Modality/Therapy: Cold packs, Massage and Mechanical t

Goals

Goals are selected very much the same way as the therapies are selected in that you MUST click the ADD ENTRY after each goal. Some goals will ask for more information to be inputted such as percentage improved. In those cases you need to click the percentage improved and you also may want to select duration (such as 40% improved in 6 weeks).

Notes

Notes are easily added to the system and will appear at the top of the report for that visit. Simply type the notes under the NOTES section in the exam screens.

Extremity Exams

We have exams loaded for the common extremities. To do an exam, first select the extremity you will be working with and then select the needed check-boxes and items from white boxes as they apply.

When you select an item in the white box they become high-lighted and you may choose another as needed. You may add choices to these by clicking Edit Options in the far top left corner.

Low Back/Neck (orthopedic) Exams

You may select Positive or Negative test results for orthopedic testing. Then you need to select LEFT, RIGHT or BILATERAL (L, R, B). Last, you need to select **Local** or **Radiating** pain, or both. You will then get a box that pops up for indicating where the pain is radiating. To customize the radiating pains, click on the Edit Options (see right) within the small pop up box on the top left, and make changes as in customizing. The new NOTES box has been added since ortho tests can require more explanation.

Muscle Strength Exams

Along with strength ratings for the left and right sides for common muscles, there are a couple of buttons at the bottom of the screen to help you easily document a “normal” or “overall” decreased patient.

For **NORMAL** + a few other findings you’ll see: Muscle Strength Tests show: Muscle testing of the upper & lower extremities finds them to be strong and equal bilaterally +5/5 with the exception of: wrist flexors (C7) were +2/5 (L) hamstrings (L-5 – S-1) were +3/5 (L).

For **NORMAL**, this is what you’ll see when selected: Muscle Strength Tests Show: Muscle testing of the upper & lower extremities finds them to be strong and equal bilaterally +5/5.

For **overall decreased**, this is what you will get when selected: Muscle Strength Tests Show: Overall muscle strength is decreased.

Left						
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Deltoid (C5)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Iliopsoas (T1,T2-L3)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Biceps (C5-6)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Quadriceps (L2-L4)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	Wrist Extensors (C6)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Adductors (L2-L4)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Triceps (C7)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Tibialis Anterior (L4)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Wrist Flexors (C7)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Gluteus Medius (L5)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Finger Extensors (C7)

Posture

<div style="border: 1px solid white; padding: 5px; margin-bottom: 5px;"> Anterior Hip Rotation <input type="radio"/> Left <input type="radio"/> Right </div>	<div style="border: 1px solid white; padding: 5px; margin-bottom: 5px;"> Anterior Shoulder Rotation <input type="radio"/> Left <input type="radio"/> Right </div>
<div style="border: 1px solid white; padding: 5px; margin-bottom: 5px;"> Apparent Lumbar Curvature <input type="radio"/> Left <input type="radio"/> Right </div>	<div style="border: 1px solid white; padding: 5px; margin-bottom: 5px;"> Apparent Thoracic Curvature <input type="radio"/> Left <input type="radio"/> Right </div>
<div style="border: 1px solid white; padding: 5px; margin-bottom: 5px;"> Elevated Iliac Crest <input type="radio"/> Left <input type="radio"/> Right </div>	<div style="border: 1px solid white; padding: 5px; margin-bottom: 5px;"> Elevated Shoulder <input type="radio"/> Left <input type="radio"/> Right </div>
<div style="border: 1px solid white; padding: 5px; margin-bottom: 5px;"> Head Rotation <input type="radio"/> Left <input type="radio"/> Right </div>	<div style="border: 1px solid white; padding: 5px; margin-bottom: 5px;"> Head Tilt <input type="radio"/> Left <input type="radio"/> Right </div>
<div style="border: 1px solid white; padding: 5px; margin-bottom: 5px;"> Head Turn <input type="radio"/> Left <input type="radio"/> Right </div>	<div style="border: 1px solid white; padding: 5px; margin-bottom: 5px;"> Lumbar Muscle Tension <input type="radio"/> Left <input type="radio"/> Right </div>
<div style="border: 1px solid white; padding: 5px; margin-bottom: 5px;"> Shoulder Translation <input type="radio"/> Left <input type="radio"/> Right </div>	<div style="border: 1px solid white; padding: 5px; margin-bottom: 5px;"> Thoracic Muscle Tension <input type="radio"/> Left <input type="radio"/> Right </div>

Posture Exams

Posture examination is as simple as clicking which bubbles apply; such as Left Head Turn, Right High Shoulder, etc. You may add the forward option to each test by clicking Edit Options in the top left corner of the exam screen and then putting a checkmark in the forward box next to the tests you want it included in. You must save and exit Quick Charts to see this change.

You can add or remove posture findings as needed from options (refer to the Customizing section below for instructions).

Reflex Exam

Along with ratings for the left and right side, there is a normal button at the bottom of the screen to help you easily document a “normal” patient.

For **Normal button**, this is what you will get when selected: Reflexes: Reflexes are normal and graded equal bilaterally.

For **Normal button**, this is what you will get when selected **and enter some other findings**: Reflexes: Reflexes are normal and graded equal bilaterally, with the exception of: Triceps were +2 (L).

The screenshot shows a digital form titled "Reflexes" with a "Left" section. It contains five rows, each with a red 'X' icon in a circle, followed by radio buttons for ratings +0, +1, +2, +3, and +4. At the bottom of the form, there are two yellow buttons: "Normal" and "Clear".

ROM Exams

As you can see from the picture at right, Range of Motion can be completed on spinal and extremities when needed.

To document ROM, simply select the measurement from the bubbles, or use the drop-down arrow for alternative selections.

Also note there is a PAIN box to specify if pain was present during ROM measurement. When a word describing the pain is chosen, a pain button will appear and when clicked, it pops up a radiating pain box. You may edit the choices by choosing “edit options” in the top left corner of the pop up. The normal button at the bottom of each region is only an ALL normal.

The screenshot shows a digital form for Range of Motion (ROM) exams. It features four main sections: "Left Abduction", "Left Adduction", "Left Dorsi Flexion", and "Left Eversion". Each section includes a scale of radio buttons (e.g., 0, 5, 10, 15, 20, 25, 30 for abduction), a "Normal ROM" value, a "Current ROM" dropdown menu, a "Pain" section with radio buttons for "None", "Moderate", "Mild", and "Significant", and a "Pain Level" section with radio buttons for 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10. At the bottom of each section are "Normal" and "Clear" buttons. The top of the form has tabs for different ROM regions: Cervical ROM, Elbow ROM, Foot/Ankle ROM (highlighted in red), Hip ROM, Knee ROM, Lumbar ROM, Shoulder ROM, and Thoracic ROM.

Clear ORTHO/ROM items individually and not entire window:

Now you can clear a single test item without having to clear the entire window of items.

All you need to do is click the CLEAR button to do it.

The screenshot shows a software interface with two sections. The top section is titled 'Active leg raise' and contains radio buttons for 'L', 'R', and 'B', followed by 'Positive' and 'Negative' options. Below these are radio buttons for 'Local pain' and 'Radiating pain', and a 'Clear' button. A red circle highlights the 'Clear' button. The bottom section is titled 'Bechterew's' and contains similar radio buttons and a 'Clear' button.

Sensation Exam

Sensation exam is set up very much like the palpatory and adjustment windows in that you click the finding(s) on top and then select your segments.

There is also a normal button at the bottom of the screen to help you easily document a “normal” sensation exam for a patient.

For Normal button, this is what you will get when selected: Touch, pin, vibratory sensations are normal.

Vital Signs

Our vitals signs include:

- Left and Right BP, Heart Rate, Respirations, Temperature
- Height, Weight , BMI, Oxygen Level

You can use as many or as few of the items as needed. The entries can be entered either by typing them in, or using the sliders to get to your desired numbers.

Growth Charting is now found in the Vitals window. See tab at the top. Change the numbers using the drop downs and then click into the chart to see the growth. You will not see anything on the chart until you have measured and recorded more than one height.

X-Rays (Views Taken & X-Ray Results)

You may note which x-rays you performed, or ordered by first click “taken” or “requested” at the top and then selecting the check-boxes for the needed x-rays. There is also now a Date of Study calendar that you can use.

X-ray findings may also be entered under the appropriate tabs at the top of this section (see tabs at the top for normal, abnormal findings.) To input findings, click the desired finding in the list and input the segment(s) as needed.

There is also an “Impressions” tab in this window with an assessment style list of choices to help you better describe the x-rays.

To add the facilities that your x-rays or impressions came from, go to Edit Options and X-Ray Facilities and add them in. You may also choose who did the study from the drop down. This list comes from your User list in the user tab of options.

S.T.I.M

This screen was recently added to show that there was no surgery, trauma, illness, or medication change since the last visit. You’ll also find a few other options there.

Review of Systems (ROS)

This screen provides you a place to record what you find when you do the ROS.

Acupuncture &/or other Custom Graphic Screens

Now you can create your own graphics window for acupuncture or other activities that may require a graphic and pin pointed areas. Simply go into the editing window (Tools/options from Main page or Edit Options from Exam input screen) and arrow over to the right end. Choose the Graphic Screens tab. From there you’ll see all of the choices of graphics that are pre-loaded. The acupuncture screen already has most listings on it, but you can add more by using the same directions as building your own below. You may add more graphics by going to a patients Body button and importing it there. Click on Add Screen and choose the graphic you would like to use from the Graphic dropdown list. Now name the screen on the right side next to Screen: Next to Report Header, choose where you would like it to appear in the reports. Use the drop down for this as well. You may also decide which screen you would like it to be accessed through. Choose that from the Parent Screen drop down.

Use the pre-loaded acupuncture screen to use as a guide to building your own new graphic screens. Type in a sentence or part of a sentence to make an introduction for the note next to “Intro”. For example: “Acupuncture was performed on the following points.” Now you can begin to click the areas that you will need. You may change the color or the size of the circle that marks the points. Now click each point you desire to name on the graphic. This will open a small window in which you

will type in the name of the new point. Click OK and move to the next point until all desired points are marked. To remove or change a name of a point, right click on the name you first gave it.

You may also want to build some quick sentences for the graphic screens you build. To do that, click the button “Checkbox Entries”. This brings up a smaller window and you will add the sentences in the box to the right of Add New Entry. Now hit the + sign and move to the second sentence. Continue adding sentences and hitting the + sign until all desired sentences are input. You may reorder those if you wish to and you may also type in an Intro sentence for these. Click Close. Now choose to Save at the bottom and when you re-open Quick Charts next time, the tab for the graphic you just created will be in the parent screen you chose for it.

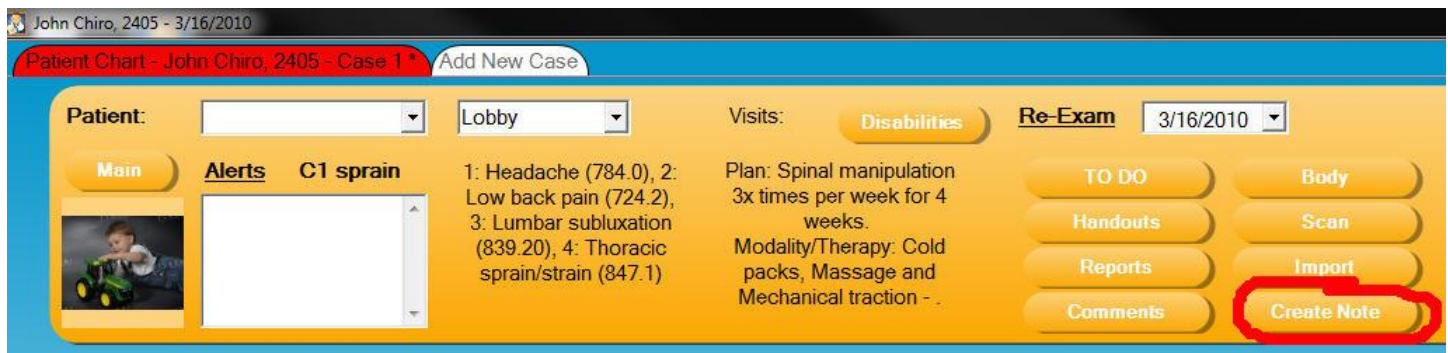
Using your Acupuncture and/or other Custom Graphic Screens

Locate the graphic window you would like to use. Click the graphics at the points you perform acupuncture (or what ever you may happen to be using it for) and, if you have added check boxes for sentences on the right, choose the necessary sentences or comments. The information will appear in the reports at the location listed next to Report Header.

Doing a follow-up visit

If you are creating a note for today for a patient, simply open the patient chart and a new note will be created.

If you are creating more than 1 note at a time, follow step 1 and then double-click on the date at top of column and change the date to needed date. Then you need to click the CREATE NOTE button at top right-hand corner of patient chart.



Next, complete any new findings by using the CLEAR button on the screens needed. Keep in mind that the findings from the last visit carry over to today’s visit in order to save you time. If something is the same today as it was the last visit then you do NOT need to modify that section.

Should you need to change that date, you need to double-click on the date at the top of the column and modify the date.

Moving from one patient exam directly into another patient’s

Now you can open the next patient’s exam screen, directly from the one you are in. Simply click on Other next to Edit Options in the top right corner and you’ll click on Next to see the patients that are on your check in list. Choose a patient for whom you would like to open the Exam/Soap window and their information will pop up for you to quickly start the next note.

Creating a new case

To start a new case, click on Add New Case at the top of the patient's chart. Type in a name for the new case and click OK. This will start a case that will be stored separately from any other cases for that patient. You may move from case to case by clicking on the proper tab at the top. You will now want to use this feature to start an Auto-Accident report. Once you have the new case you'll still scroll down to the part of the chart that says Auto Accident and click into that section to bring up the related questions. Once you save that screen it will become your Auto Accident case for that person. You may show that the case is active by right clicking on the tab and choosing "set case as active". You may also rename or DELETE the case with a right click.

Deleting a visit

To delete a visit from a patient's chart you start by opening their chart. Then find the column with the date you need to delete. Right-click on the date itself above the data and select delete visit. You then need to enter the system password before it will allow you to delete the visit. Click OK when you have entered the password. The default system password is "staff". You may also keep the visit date and column and just delete the information in it with a right click. Choose "clear visit" and you will also enter "staff" to complete this action.

Changing the Date of Visit

To change the date to a past date on a note, just double click on the date and click in to change it to what it needs to be. To create another date just hit the Create Note button. You can continue changing the date and creating a new note until you are caught up. Just remember to go back into each date and put in the correct details of the visit before carrying it over to the next date.

Quick way to move to another date in the chart

To get from one date to another just use the grey scroll bar at the bottom. To do it even quicker you may right click over the current date and choose the date that you would like to go back to by choosing Jump to Visit.

Creating reports/notes (Microsoft WORD must be installed in order for reports to work)

From a patient chart

To create a report from the patient chart first open the patient chart (follow prior steps if you are unsure how to do this). Then at the top right-hand side of the patient chart click the REPORTS button.



Then there are many options for reports:

- Initial Visit/Soap Note
- Date Range of Notes
- Patient History
- Entire Case Report
- Superbill reports
- Auto Accident
- Recommended Treatment

The **initial exam/soap reports** will allow you to create reports for any visit the patient has had. You can create these for just a single visit, or for an entire date range. To create a report for a single visit, click the drop down for single visit and select which date you would like to create. There will be a date listed for every time the patient was seen. Then click the OPEN REPORT button. For a date-range of reports click the first date box and select the beginning of the date range. Then you will also need to select the date for the second date box which completes your range of dates. Then click the OPEN REPORT button.

The **Patient History Report** will show all of the complaints a patient has had so far.

The **Audit Log** report will show you who has logged in per doctor name.

The **Entire Case Report** shows exactly what it says: a report of every visit the patient has had in your office. This is helpful to use when treating a patient for a PI or auto-accident case.

The **Shortened SOAP Report** is a quick report of the complaints, palpation and adjustments, and the treatments.

The **Auto Accident Report** will show the details that have been entered for a patient's auto accident. This is also useful in PI cases.

The **Superbill Summary** gives each person's diagnosis & treatment codes for the date or range of dates chosen.

The **Recommended Treatment Report** will show the patient what's been done, equipment you send them with, nutrition/supplements recommended and what they should be doing at home.

The **Auto Accident** and **X-Ray** reports are self explanatory.

The screenshot shows a software interface for generating reports. On the left is a list of report types: Initial Exam/Soap Report, Superbill Summary, Patient History, Entire Case Report, Superbill, Auto-Accident Report, Recommended Treatment, AA Final Narrative, AA Initial Narrative, Doctor Care Update, Doctor Referral Update, Patient Referral Request, Patient Thank You, McReport, New Report, and MediCare. On the right are input fields: Report Start Date (3/16/2010), End Date (3/16/2010), and Single Date. There is a checkbox for 'Include Referral' with the text '1 visit for the date range.' and a 'Contact' dropdown menu showing 'A, Auto'. At the bottom are four buttons: Select Patient, All Patients, Open Report, and Cancel.

Lastly, most of your reports can be turned into a **referral letter** by simply clicking the “Include Referral” button and selecting which referring doctor/attorney you would like to address the letter to. Each report will have the date, patient's name, and doctor's name. You will have to add page numbers by going to the top of the document and going to Insert and down to page numbers if you want page numbers on the report.

The **Narrative Reports** will self insert the correct details depending on what patient you are in and who their contact was. You may modify the body of these letters in the Letter Reports tab of the Tools/options.

Not using certain reports in the list?

Turn off any reports you don't want to see by going to the Tools/options/ Letter Reports tab. Check them off in the top half of that window.

Select which items show up on soap notes:

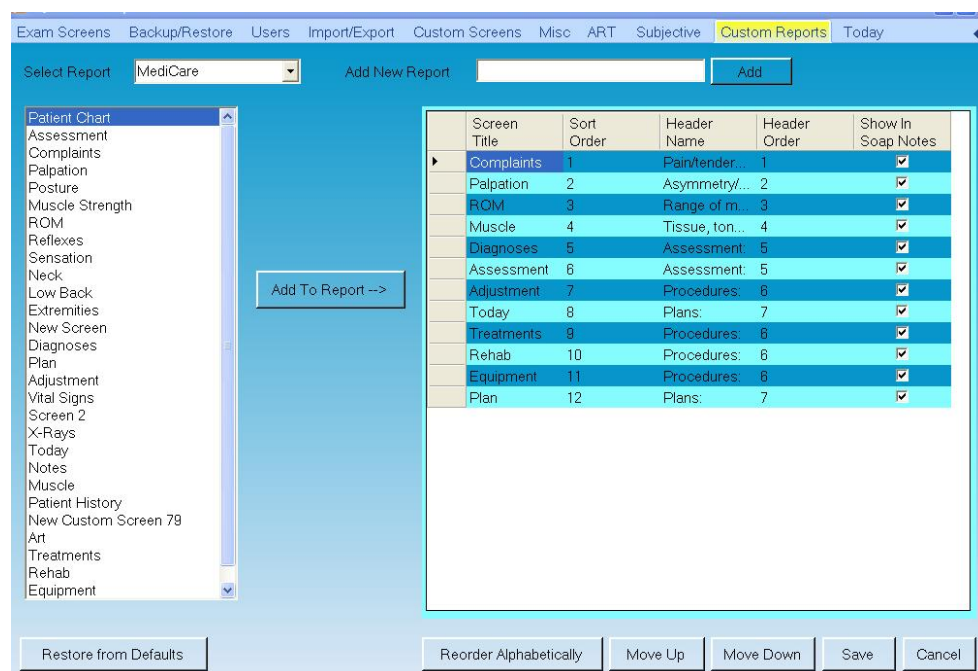
You may select which items show up on a soap note (perhaps you would like your ROM or ORTHO tests to do this).

To do this go to Tools/Options from main screen and click the 'Exam Screens' TAB. Then select the 'Exam Screens' item from the drop-down list.

Now you should see a check box on the right-hand side which allows you to select or remove items from showing on the soap note.

Creating a Custom Report

You may choose what you want in your reports. Just go to Tools/options and the Custom Reports tab. You may have to scroll to the right past Misc. In the Add New Report section, type in the new report name. Click Add. Now you should see the new name in the Select Report drop down. Choose your new report and you'll see the screen on the right side go blank. You may now choose from the list on the left and click Add to Report after each one you choose. When you have everything that you want in it, you may change their order by highlighting and using the Alphabetical, Move up, or Move down buttons as the bottom. Save when you have it the way you like it. You should immediately see it as a choice at the bottom of the other reports available.



Customizing Letter Reports

To customize the letter reports found in the Reports button of the patient chart, go to Tools/Options/Letter Reports tab (you have to arrow to the right to see this). Find the letter you want to modify and click into the middle where you see the body of the letter. Double click to put your cursor in the letter and then use the arrow keys to move up or down within the letter. Items that appear in the [] will automatically insert into the letter based on whose chart you are in. Here are the other items that you can insert using square brackets:

[Abnormal XRay Findings],[Acupuncture],[Activator],[Activator – Extremities],[Adjustments],[ART],[Assessment],[Complaints],[Diagnoses],[Elbow Exam],[Equipment],[Foot/Ankle Exam],[Gait, Grip, Leg Length],[Gonstead][Hand Exam],[Hip Exam],[Home Therapies],[Impressions],[Knee Exam],[Long Term Goals],[Low Back],[Muscle][Muscle Strength Exam],[Neck],[Nutrition/Supplements],[Palpation],[Patient History],[Patient Responsibilities][Plans],[Posture Exam],[Prognosis],[Reflexes],[Rehab],[ROM],[ROS],[S.T.I.M.],[Sensation],[Short Term Goals][Shoulder Exam],[Today],[Treatments],[Vital Signs],[Wrist Exam],[X-Rays] You may also put the following in square brackets for auto-insert: Date, PatientName, DOB ,Gender ,Diagnoses, AutoAccidentAndSubjective, IncidentDate, DoctorName, ReferrerAddress, ExamFindings

Customizing

Customizing is done from our options section. This can be accessed by going to Tools/Options from the main screen. NOTE: All customizing except screen colors will not take affect until the program is closed and opened again.

Customizing screens

Screens can be customized in a number of ways. You may customize the:

- 1- Colors of your main screens
- 2- Colors of the patient check-in screens
- 3- Patient chart grids (the order of the rows of data such as palpation, plan, etc)
- 4- Patient exam buttons (the order of the exam buttons such as palpation, plan, etc)
- 5- Add new windows/screens in the exam section

1- To customize the colors of the main screens first go to tools, options from the main window. Next, select the VISUAL OPTIONS tab at the top.



Then you can modify the Main Window background color by selecting the blue box to the right of the white text box that shows 1,153,203. Simply set to whatever color you like and if you make a mistake, or do not like the color, simply click the 'restore from defaults' button in the bottom left-hand corner of the window.

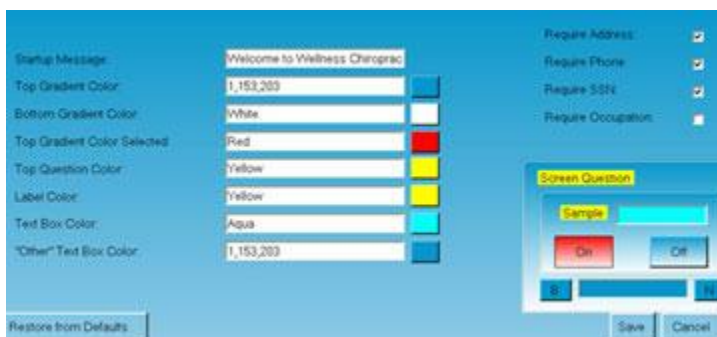
Follow the same steps to change the grid colors. The grid colors are the colors on the main screen where the patient list/to do list are displayed. Changing the grid colors will also change the colors of the grid inside the patient chart (travel-card) screen/section.

Once you are finished changing the main window colors click SAVE or simply close the options window.

2- To customize the colors of the patient check-in screens first go to tools, options from the main window. Next, select the SIGN-UP OPTIONS tab at the top.

From here you can change the welcome message (Startup Message) by simply typing what you would like the patient check-in screen to display.

You may also change the color of the headings, questions and button colors. When you make changes, there is a small sample display so that you can see how your changes will look. Don't forget you can use the 'restore defaults' if you make a change you do not want to keep!



3- To customize the Patient Chart Grids (the order of the rows of data such as palpation, plan, etc),

First, go to tools, options from the main window. Then select “Patient Chart Sections” from the drop-down list.

Next, select the EXAM SCREENS tab at the top.

Then you may move an item up or down by first selecting the item and then clicking the ‘move up’ or ‘move down’ button at the very bottom.

You may also decide you will never need to see an item, in which case you may select the check-box for DELETE and it will not show up.

Once you have the items where you want them, close the options window. **NOTE:** You will need to close and re-open the program before these take affect.



4. To customize the Patient Exam Buttons (the order of the exams such as palpation, plan, etc)

First, go to tools, options from the main window.

Next, select the EXAM SCREENS tab at the top. Then select “Exam Screens” from the drop-down list.

Then you may move an item up or down by first selecting the item and then clicking the ‘move up’ or ‘move down’ buttons at the very bottom of the screen.

You may also decide you will never need to see an item, in which case you may select the check-box for DELETE and it will not show up.

Once you have the items where you want them, save and close the options window.

NOTE: You will need to close and re-open the program before these take affect.



Customizing patient check-in, history, or complaints

You may customize some of the questions relating to the patient check-in. This is very limited and allows you to do things like add a specific type of allergy, or another answer to already existing question in the system.

To customize the Patient Check-In first go to tools, options from the main window.

Next, select the SIGN UP SCREENS tab at the top.

Find the item you wish to add/remove an item from and click the PENCIL icon to the left-side of the name/sentence.

To add a question, scroll down to “Please answer the following questions, click on the pencil, then the + sign to add the question.



Once you have the item open, you will see a screen similar to the screen below.

The common items are: Add (blue PLUS + sign), Remove (check the delete column at right end) and Modify/Edit (the yellow PENCIL icon).

If you need to **add** a new item, click the BLUE PLUS sign. Then type the name of the new item and click SAVE to add it to the list.

If you need to **delete** an item, check the delete in the box at the right end.

If you need to **modify/edit** an already existing item, click the YELLOW PENCIL icon. Then modify the text and close options when you are finished.

			Option Text
			Ankle Pain
			Arm Pain
			Arthritis
			Asthma
			Back Pain
			Broken Bones
			Cancer
			Chest Pain
			Depression/Other disorder
			Diabetes

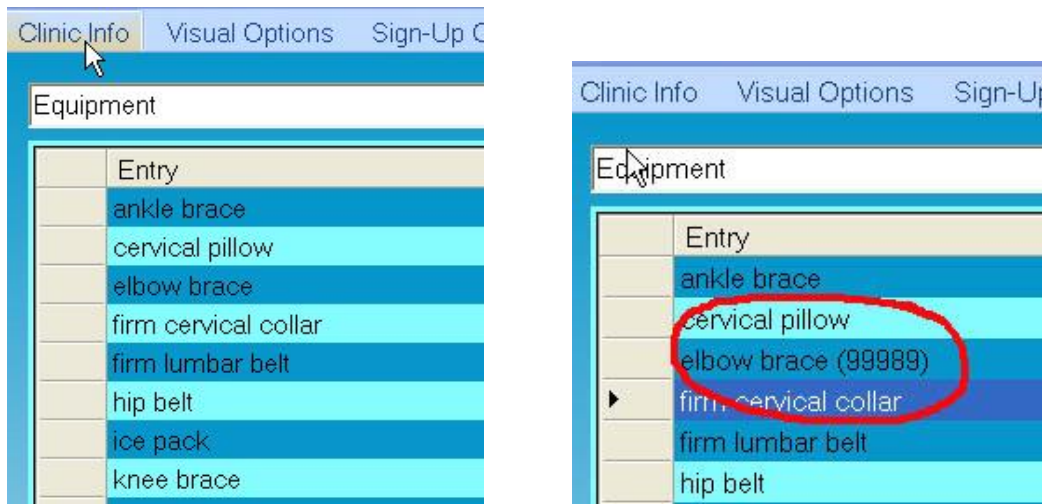
*The program will need to be closed and re-opened in order for changes to take affect.

Equipment can now have codes added to each of them:

You can now go into your options and find equipment and give it a code if you want it to appear on your billing statement. To do this you need to open your Tools/Options/Exam Screens and find the item for Equipment in your drop-down.

Then select the item you wish to give a code to, and enter the code in () parenthesis like this: Knee Brace was provided (45445).

These codes will not transfer to your billing software when you export.



Customizing exams

Customizing exams is all done by going to our tools > options section. Then go to Exams Screens.

(See Sample Screens Below)

From here you have many items in a large drop-down list. Each one correlates with an item in the exam section that you can modify. For our example, let's say we wanted to add an entry to the palpation exam.

We choose the Palpation Conditions from our drop-down list. Now we can add, modify or delete an item.

To **add** an item, we simply click the bottom field (as I have done below) and type your new entry.

To **modify** an existing item, click on the word so it becomes high-lighted in blue and then you can type over the entry.

To **delete** an item click the check-box on the right-hand side that has the word delete at the top of the check-boxes.

You may also change the order of the items. You may move an item up or down by first selecting the item and then clicking the 'move up' or 'move down' buttons at the very bottom of the screen.

When you are finished adding your changes, simply close the options window. The program will need to be closed and re-opened in order for changes to take affect.

HINT: Want a shortcut way to get to the exam options for a specific item?

From your patient exam window, simply go to the window you want to make changes to. In our example, let's change Plan.

First we open a patient, and are in the exam section for them.

Next, we go to the plan button.

Now, we use the EDIT OPTIONS button in the top left-hand corner (as shown to the right).



The EDIT OPTIONS button will take you directly to the item you want to modify by using these steps. To customize the Radiating Pains for complaints, go to the same scroll window and scroll down to Radiating Pains. All of the radiating pains will be listed there categorized by complaint.

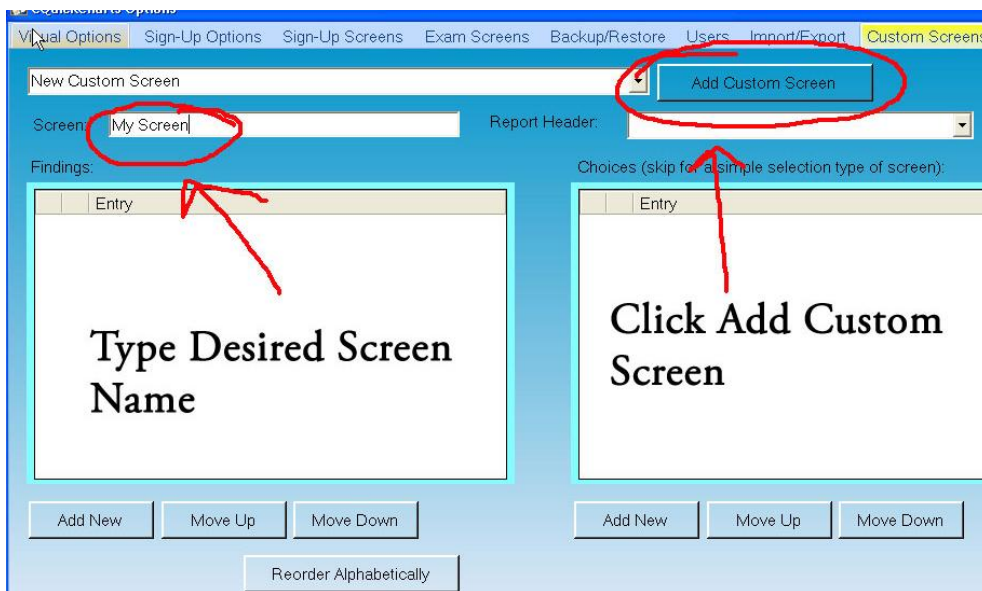
Creating a custom window

First open your options screen (tools/options from main screen). Then click the CUSTOM SCREENS tab at the top.



Next click the "Add Custom Screen' button.

Then type desired screen name under the screen field on the left-hand side.

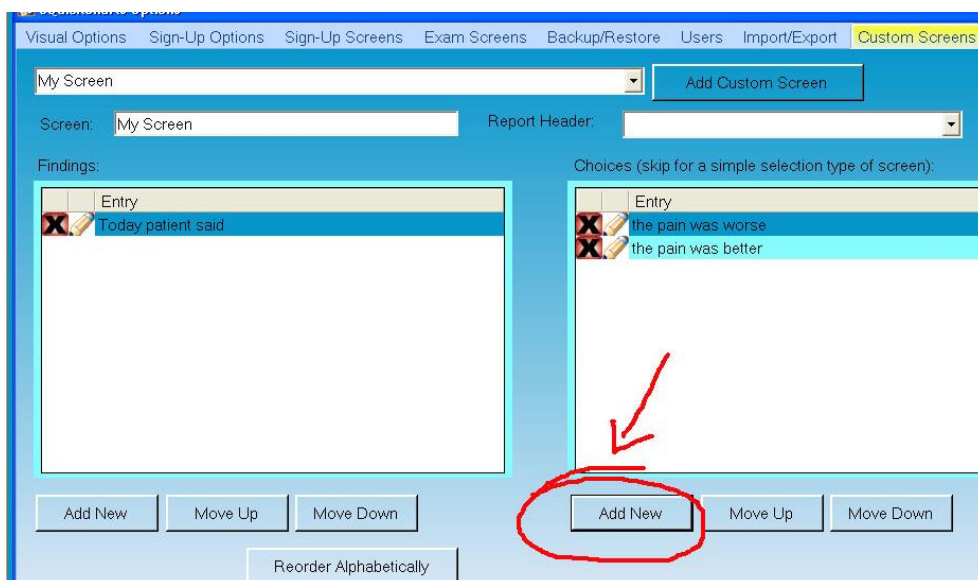


Next, add your desired findings (could be many sentences or just a single word that will be related to more choices) by using the ADD NEW button at the bottom left of screen.

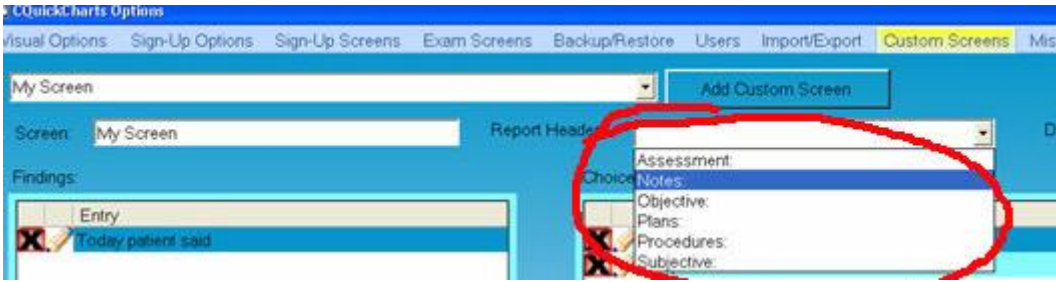
Then add your desired choices (if any) by using the ADD NEW button at the bottom right of screen.

To delete the custom button, simply click on the Delete Custom Screen button.

*You will now have an "Input Details" box within your new custom button. This will allow you to add details that you formerly were unable to add.

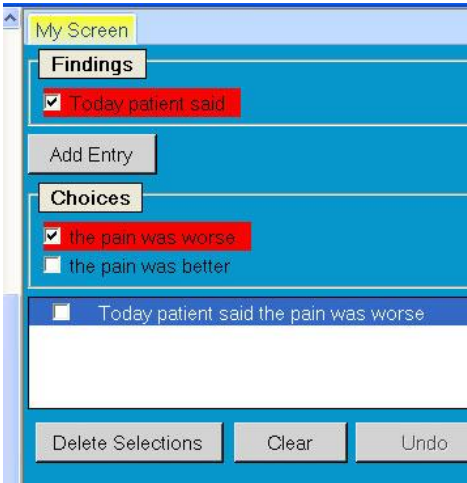


Last, select which heading your new items belongs to with regards to the reports/notes (i.e. subjective, objective, etc).



Once your new entry is ready to be used, simply close the options window and then close the entire ForteEMR system. Upon reloading the system, your new window will appear in both the patient chart section and the patient exam screens.

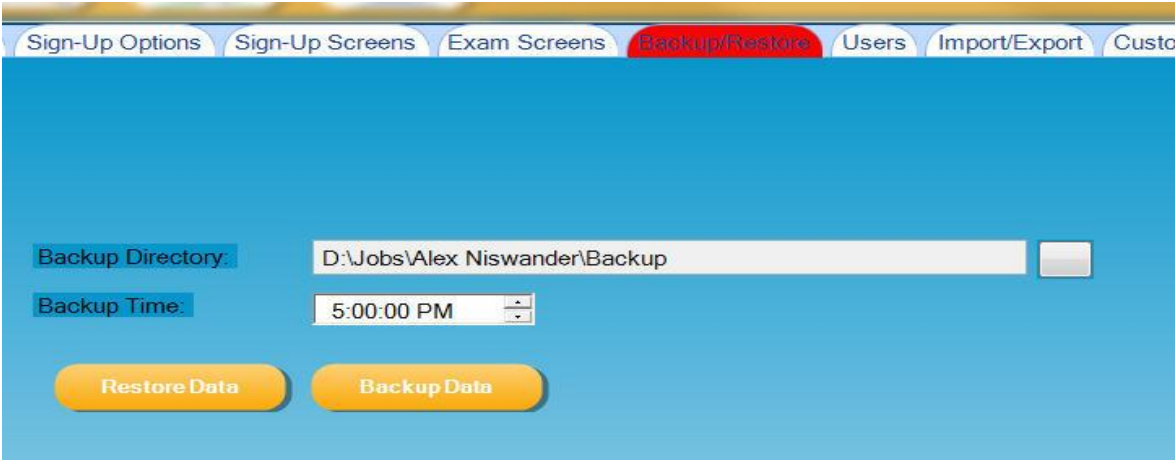
Our example new window looks like this:



Backing Up the System

In the customizing window (tool/options) go to the Back Up tab. There you will be able to back up the system to a file in your computer at a specific time each day. It can do this automatically at the time you choose or you can click the Back Up Now button to do it on command.

The **Backup** process built into CQC is the first line of defense against data loss and corruption. It provides a quick and easy way to restore data to your system in the event of system failure or data entry issues.



To setup the backup feature, start by picking the location that the backup will be stored. In the example, the chosen directory is C:\Backup. If you are backing up to a new directory, you will need to

ensure that the location exists before you try to configure Quick-Charts. You may also direct the backup to an external drive attached directly to your server.

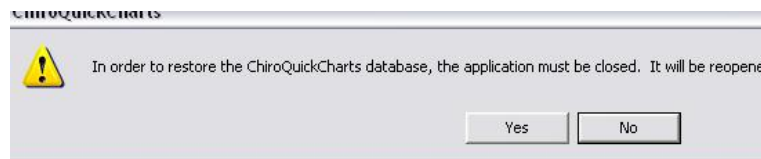
You also need to set the time that the backup will run. In the example, the time chosen is 7:20PM. We recommend that you schedule this to run after all of your notes for the day have been entered and nothing new will be added to CQC until the next morning.

Once you have picked your location and time, you can test the new settings by clicking the “Backup Data” button. If everything was configured properly, you will see the following message.



To restore data from a backup, first ensure that all users are out of the system and that CQC is not running on any of the workstations or Kiosk machines and that the Quick-Charts services are shut down on the server. If you are unsure how to do this, please contact our support office for assistance.

Once everyone is out of the system and the services are turned off, click on the “Restore Data” button. You will be presented with a screen that looks like to following.



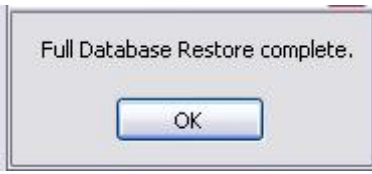
Choose yes, and allow Quick-Charts to close. You will then be prompted for the Staff Password to continue with the restore.



Enter your Staff password and choose OK. This will bring up the restore window. Make sure that CQC is closed and then hit Restore Data. Be sure to click the button only one time.



The data restore should take only a few moments. When it is complete, you will see the following message.



Congratulations! You have successfully restored Quick Charts! You may now have users log back in and go back to work. Your database will be current as of the date and time of your last back up.

****The backup feature is a great way to restore CQC, but should not be considered a replacement for a full backup of your server and any other important electronic data stored on your network. We highly recommend that you speak with your local technician about full off-site backups off all of your systems and software including Chiro Quick Charts.**

ForteEMR Upgrade 12 Feature List: (JAN 2011)

- Ability to export equip/supp codes/x-ray codes with a way to choose the ones they want to export with today's export
- Ability to add the name of the person who took the x-rays or impressions
- Ability to tell when the test was taken
- List facilities that perform the x-rays or impressions
- Ability to populate a list of common problems on tests and relate them to the specific spinal levels or other body parts (under Other in Exam screen)
- Create a default statement that shows up unless something is selected in x-ray recommendations.
- Abnormal x-ray and impression added pop ups rather than using add entry
- Delete wrong contacts when linking to patient
- Ability to get to ToDo list from main screen (drag and drop patient there)
- Ability to default image category
- Subjective, Today, and Assessment show up with right click in each complaint
- Ability to get to another date without having to go back to patient's chart
- Enhanced ToDo list so it will do certain things on certain visits
- Emailing to patients (in mass, too)
- Ability to delete and restore stock reports – under options; reports w/letters
- Ability to delete custom reports
- Stay on most recent date after deleting a visit
- Added "family" for a more generic choice in family history or choose nothing
- Automatic Log Off – User list
- Plot and display growth charts
- Ability to maintain up-to-date problem list
- Added audit log
- Ability to customize improvement screens in ADL/plan and/or assessment - kiosk
- Added templates per exam type
- Ability to make a shorter SOAP report
- Added 1 – 10 grading to palpation screen (rt click preview sentence)
- Add Review of Systems
- Added L & R to SI in Gonstead listings
- Ability to lock down tools/options unless administrator, which means tools/options can be hidden and special admin log in.

Ability to keep “non-admin” staff from deleting data
Ability to import logo to be at top of reports/handouts
Added “minimum” and “unbearable” to intensity in complaints
Added “none” to L R B and add C for “central” in complaint
Changed gender to an simpler radio dial instead of drop down
Added a Clear All to the diagnosis window
Added a “Save and Close” to pop up windows
Added a Fax column for Contacts
Pop up for chat in all parts of software, so you can see when there’s a msg
When checking in from Eclipse, they check into QC
Ability to lock down daily notes so no changes can be made without password and recording of who did it. Also the date of the lockdown.
Remove capital letters in body regions.
ToDo will change color when something is on it
Ability to go to a past date from patient chart, right click over date

ForteEMR Upgrade 11 Feature List: (MAR 2010)

Complete overhaul on the look so as to keep interest and create new interest in the system. This is a very large programming change and will account for most of the upgrade.
Imported and scanned items will now be seen in a preview window to the right of the patient chart and will enlarge with a click of the mouse
Print visit with a right click over the patient chart date
Units were added to simplified treatment window so use of Add Entry key can completely be eliminated. Turn on Simplified TX in the last row of the Misc in Tools/options.

ForteEMR Upgrade 10 Feature List: (NOV 2009)

In the vital sign section we added supine BP
Assessment per complaint. Pop-up assessment window opened from general complaints and each individual complaint
Bracketed lists popup for Simplified Tx (location, minutes, and LBS once you create it)
Diagnoses popup on right-click for each finding in Simplified Treatments
Added Thyroid, high blood pressure, high cholesterol, anxiety to our list of reasons for use of medications
Randomizing of subjective text, including complaints
Ability to have the Daily Patient Comment high-lighted in the Tooltip to show daily comment
Moved the “forgot password” button to a better location in patient check in kiosk
Set a closing remarks section where the doctor can type as much as necessary under his/her signature graphic
Ability to add pounds option to treatment entries
Narrative Reports & Discharge Summary/Final Report

ForteEMR Upgrade 9 Feature List: (OCT 2009)

Pop up for Subject statements
Custom reports so you can put what you want in them
Ability to select more then one assessment statement

Addition of TMJ, cranial, sub-occipital, cer-thoracic, thor-lumbar, lumbo-sacral, abdominal to ADJ and Palpation windows

Addition of cranial, abdominal, TMJ (Temporal Medibular Joints), Coccyx, Spenoid, parietal bones to ADJ window

Ability to clear everything but the date of a visit with one click

Enlarged treatment preview box so many entries can be seen without scrolling

Removed the word NOTES from all note and custom windows so only text shows

Added equipment/rehab back to patient chart sections

Ability to remove the "pain level=0" when it is negative in Ortho Tests

Add footer to pages in reports. Includes date, patient name, and doctor

Visit date shows at top of Exam/SOAP screen

Added NONE to clear better/same/worse from complaints screen

Many new reports preloaded

Ability to erase date in X-rays

Ability to customize the Radiating Pain list for complaints

Option to make the DX codes be listed in the order they are clicked instead of alphabetical

Auto Report was moved to the beginning of Entire Case Report

Use Control "F" to pop up the Find Patient window from anywhere in the system

Ability to email the handouts (patient must have email listed in Edit Patient)

New layout for the ART window

Two way interface for EZbis billing software

Anti-psychotic added to reasons for medication, more to come in next upgrade

Detailed paragraph capabilities in the Treatment selections

Simplified treatments now show up with each line separate from the last choice in preview, patient chart and reports

Ability to have detailed treatments listed in Simplified Treatments

Added Medicare report

New handouts and graphics added

Today button that provides you with the ability to further describe patient encounters such as how patients respond to care and the plan for moving forward

ForteEMR Upgrade 8 Feature List: (JUL 2009)

Add BACK UP NOW feature to the backup window.

Add helpful dashes to the text boxes such as phone, SS#, etc

Add "John said condition started on (blank)" so you could write last month, last week, or a date.

Ability to close a patient chart from the chart

Added "Impressions" tab to x-ray section with assessment style list of items

Clear CHAT at end of each day automatically

Rooms – access to change them in the patient chart for moving them from there

Way to keep people on hold when they have notes that need to be completed on main page

Added patient name to top of patient education hand outs

Note Input Box for each orthopedic Exam box since these tests are not cut and dried.

Added ability to have 'input details' in the custom screens for more flexibility

Added the ability to delete custom screens no longer needed from the custom screen builder

Added the ability to customize extremity list of tests/etc/scroll bar fixed

Removed the SAVE button and added BODY button in the Adjustment window

Add back the transfer of levels from PALPATION to ADJUSTMENT screen.

Sped up the time it takes to load a chart as fast as 5 seconds depending on RAM & age

Added ability to move from 1 chart to the next in your check-in list with a button from within the patient's chart

Added ability to move from 1 patient visit, to the visit for the next patient in your check-in list with a button in the Exam area of the current patient you are working on

Ability to move to patient visit for today with a right click on check-in list, bypassing the patient's chart and going directly to their Exam area

Add better/same/worse so it exists per complaint on patient kiosk check-in process

Items entered into Radiating Pain list will not stay capitalized

Color coordinate buttons so they change colors after the screen has been visited for that patient.

Different color if you just visited but didn't make changes/additions in that window

Change colors for items that have changed today vs. last time

Ability to delete cases (must not have anything in complaints for that case in order to function)

Ability to assign a user doctor to each visit in the patient chart – also affects the exported Dr. for Eclipse/Medisoft

Speed – loading of charts should be about much faster as well as the time it takes to switch from chart to chart

Added accident history list to the patient history window (bottom half).

Ability to add to main ToDo list with a right click over a current entry

Export to chosen Eclipse locations using button in Treatment window

ForteEMR Upgrade 7 Feature List: (Jan 2009)

Ability to have multiple cases - a way to select a drop down from chart and have separate note sections –

Active case has asterisk on its tab. Set tab as active or rename it with a right click.

Added scroll bar to the text box on the travel card screen

DX list - modify the pop-up order list so there is a button (reorder) that launches instead of always coming up.

Set up find patient window to display alphabetically.

Superbill Summary Report for more than 1 day is separated by date instead of running together

New ART palpation window

Added accident history list to the system

Added an EDIT OPTIONS link to TODO list in chart – still can't hide ones that are in use by at least one patient.

Added an EDIT OPTIONS link to ADLS list in chart?

ForteEMR Upgrade 5/6 Feature List: (Oct 2008)

Highlighting & Date to printed handouts

Print button for treatment & supplements/equipment section (also added treatment report)

Add Diagnosis Categories in the edit options under exam screens

Ranges of palpation/Adjustments (like C1-5 instead of C1, C2, C3, C4).

Added Social History section

Clear patient's DX from the treatment window with a right click.

Ability to use Negative with ORTHO tests.

Added Mild/Moderate Severe to Palpation for pain rating, etc.

Ability to use Negative with ORTHO tests.

Added Mild/Moderate Severe to Palpation for pain rating, etc.

Added Radiating Pain to Muscle Findings section (under muscle palpation window)

Ability to add new items with a + sign in Assessment/DX/Plan sections.

ECLIPSE: Added Cases/UNITS

Ability to set a DEFAULT tab in each window in exam screens. Example: Make treatments first tab that opens instead of the adjustment tab.

ORTHO TESTS:

- Ability to use both local and radiating pain.
- Radiating pain becomes customizable list.
- Create a local pain pop-up list to specify where local pain is.
- Added 1-10 pain scale list for positive ORTHO tests.

ROM:

- Customizable pop-up box for indicating where pain is.
- Added 1-10 pain scale as well.

Pelvic listings will allow both LEFT and RIGHT to be used at same time (re-work fix of already existing feature).

Added Auto-Accident Q/A input to the patient's chart. Just click on that section in the correct date.

Added coloring to today's visit in patient chart (highlighting of sorts).

Ability to print screens like patient demographics, tests, options, etc throughout the program.

TODO list clears in both main screen and patient chart when you clear on main screen.

Fix all CAPS in reports for extremities and vitals.

Added Getting Started Guide to the system when first launches to help customers learn how to create a patient, note, etc.

Ability to make changes in Patient Checklist / ToDo button within patient chart

Added dialogue box beside complaints

ForteEMR Upgrade 4 Feature List: (July 2008)

New windows can be added to exam section by users (options/customizable screens)

Added CREATE NOTE button in top-right of chart for creating a new note

Enlarged width of text boxes in new/edit contacts

Add ability to keep patients checked in on main screen (tools/options/misc keep checked in)

Now can add new items below each history section (allergies, surgeries, etc) with a +

sign

Checkboxes below windows such as palpation, adjustment, were moved to the right (touch-screen)

Added NONE to intensity and frequency and other subjective entries

New COMMENTS section at top of chart for notes such as 'missed appointment today, etc'

Added a 1-10 box for ordering the diagnosis codes

Add oxygen level to Vital Sign screen

Added ability to customize which items show up on specific reports (options)

Medical History is now included on the auto accident history report

DB Consultants/ ASPC demographic INTERFACE

Added Anti-Depressant to list of med-types (patient kiosk)

Set 'experienced before' to clear itself after first time a new complaint is used.

Generally cleaned up some of the report grammar and layout

Removed the '0 is none and 10 being excruciating' from soap notes report wording

All findings in exam screens highlight in RED to better see selections

Added ability to add a date to the x-ray section & shows on x-ray report

ForteEMR Upgrade 3 Feature List: (May 2008)

"View Only" choice for patient chart

Right, Left, Bilateral Option to Complaints

Added 0 for pain scale in patient check-in

Added "unsure" to start date for complaints in patient check-in

Activator Adjustment Listings

Customizable Listings for Pelvic/Sacrum

Pop Up picture of body graphic

Clear ALL for complaints

Added UNDO button in the exam section

ToDo list in patient chart can also display on main screen

Way to show visit was cancelled

Equipment codes may now be added

Show items from the notes section in the preview text box

Removed "complaint started on" for soap notes

Clear ORTHO/ROM items individually and not entire window

Duplicate Patient alert for already existing chart information

Customizable Pop Up window time (tooltip duration)

Change check-in color of patient after specific time period passes

Clear chat screen button

ForteEMR Upgrade 2 Feature List: (March 2008)

Customizable Check-In Be able to add questions of your own to patient kiosk

Disable/Enable ToolTips- Be able to turn off tool tips/popups

Treatments as Check-box list- instead of bubble style

Diagnosis Linked to treatments- link these together in treatment window

Shoe Size for patient to input in demographics window

Normal Button for ROM

ROM add more buttons for the lower values,
Nutrition/Supplements Section – prescribe these
Medisoft export, Eclipse Export
Ezbis import, Chiro8000 Import
Ding Sound Added for Chat Send w/ disable/enabling in options
Gait, Grip & Leg Length (left leg length is X MM longer than other leg)
Ribs-added to palpation list (more explanation coming soon on this one).

ForteEMR Upgrade 1 Feature List: (Jan 2008)

Customizable handouts- Add/modify/delete handouts
Notes for each section- Add notes to every section
Global Superbill Report- See a day sheet of all
patient/codes for the day
Adding Graphical Signature- Scan and use a signature
ROM Change 40/50
Note Date/Time Stamp- Date/time stamp can be applied to
notes
Patient TODO list- Add a ToDo list
Inking- Graphics of the body
History from chart
Alert for re-exam, alerts, new complaints, and number of
visits are met