

Practitioner – Client Record Self-Evaluation

The following list can be used for self-evaluation for your client/patient records to identify strengths and weaknesses in record-keeping practices and documentation.

Client Record keeping Activity	Yes	No	Action Required
My record keeping system allows for ready retrieval of an individual patient file.			
My records are legible			
My abbreviation Legend is available and is the abbreviation Legend commonly used by all health professionals			
My Records are written in English			
My Records are written in another language other than English but also with English translation			
The client/patient's identity is clearly evident on each component of the file			
A signed Consent for Treatment Form forms part of the record			
Each client/patient file clearly shows full name, address, date of birth, gender			
The date of each consultation is recorded			
The family history, functional inquiry & past history (including significant negative observations) is recorded and maintained			
Allergies are clearly documented			
An updated list of current medications (including 'over the counter' vitamins and herbal preparations) is recorded in the file			
Lifestyle factors such as smoking, special diets, exercise, alcohol consumption and recreational drugs are recorded			
A 'cumulative client profile' relating to each client is present and fully maintained			
The 'presenting condition' (primary complaint) is clearly stated			
The duration of symptoms is noted			
An adequate description of the symptoms is present			
Positive physical findings are recorded			
Significant negative physical findings are recorded			
Records of external laboratory tests and other investigations are included with the client/patient records			
A signed 'consent to release confidential Information' is evident in the case of a need for referral			
All letters of referral are maintained within the record			
Requests from the client/patient for consultation with other health care practitioners are documented			
The assessment of signs and symptoms is recorded			
The treatment plan and/or treatment is recorded			
Doses (number of required treatments) and duration (length of each treatment) of prescribed remedies are noted			
Progress notes relating to the management of clients suffering from chronic conditions are made			

There is documented evidence that periodic general assessments are being made			
There is evidence that adjustments to the Treatment Plan are being made to match the progress of the periodic general assessments			
There is documented evidence that health maintenance is periodically discussed (topics such as exercise, lifestyle changes etc)			
There is evidence that the practitioner periodically reviews the list of prescribed drugs, supplements, remedies etc. being taken by client/patients suffering from multiple or chronic conditions			
In the event that more than one practitioner is making entries in the client file, is it evident that each practitioner is identifiable?			
Information about possible negative outcomes of treatment given to the client/patient is recorded			
Evidence of client/patient non-compliance with practitioner recommendations and the course of action taken to assist the client/patient to become compliant is maintained in the records			
Documented evidence of specific activity given to the client/patient to carry out between visits is maintained in the records			
Phone conversations and any home visits are documented in the client/patients records			
If a transfer of client records is requested all written requests, fees charged and obligations are recorded in the records			
Notes:			