Your job is to carry out an audit to determine the quality of a clinical note. First, analyze the provided note and then analyze the provided questions. Finally, generate a report that answers each of the provided questions based on the analysis of your note and provide a final score. Do not include the note in the audit report:

<questions>
1. Are the techniques and interventions documented in checkboxes also described in the

1. Is the patient's chief complaint clearly documented and does it align with the services provided?

2. Are the history of present illness (HPI) and review of systems (ROS) documented comprehensively?

3. Are the patient's vital signs (blood pressure, heart rate, temperature, etc.) recorded and do they match the clinical narrative?

4. Is there a detailed physical examination documented, including findings relevant to the patient’s complaints?

5. Does the clinical assessment and diagnosis justify the treatment plan and interventions provided?

6. Are the prescribed medications, dosages, and patient instructions clearly documented?

7. Are the patient's past medical history, family history, and social history documented and relevant to the current visit?

8. Is there a documented plan for follow-up care, including specific instructions and timeframes?

9. Are the CPT codes and ICD-10 codes used accurate and reflective of the services provided and the documented diagnoses?

10. Is there evidence of patient consent for treatment and any procedures performed during the visit?

</questions>