

Patient's Name _____ Date of Exam _____ Claim Number _____

6. MOTOR STRENGTH (standing, walking, seated, or supine) **GRADE (OUT OF 5)**

	NORMAL	ABNORMAL	LEFT	RIGHT
6.1 Hip flexion	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
6.2 Hip extension	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
6.3 Hip abduction	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
6.4 Knee extension	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
6.5 Knee flexion	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
6.6 Ankle dorsiflexion	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
6.7 Ankle planter flexion	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
6.8 Great toe extension	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
6.9 Heel toe walk	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
6.0 Toe walk	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

7. SENSORY (pin prick) (seated or supine)

	LEFT			RIGHT		
	Normal	Diminished	Absent	Normal	Diminished	Absent
7.1 L3 sensory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.2 L4 sensory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.3 L5 sensory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.4 S1 sensory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.5 Comments	_____					

8. REFLEXES (seated) (+2normal)

Patellar	8.1 Left	<input type="checkbox"/> 0	<input type="checkbox"/> +1	<input type="checkbox"/> +2	<input type="checkbox"/> +3	<input type="checkbox"/> clonus
	8.2 Right	<input type="checkbox"/> 0	<input type="checkbox"/> +1	<input type="checkbox"/> +2	<input type="checkbox"/> +3	<input type="checkbox"/> clonus
Achilles	8.3 Left	<input type="checkbox"/> 0	<input type="checkbox"/> +1	<input type="checkbox"/> +2	<input type="checkbox"/> +3	<input type="checkbox"/> clonus
	8.4 Right	<input type="checkbox"/> 0	<input type="checkbox"/> +1	<input type="checkbox"/> +2	<input type="checkbox"/> +3	<input type="checkbox"/> clonus
Other	_____					

9. STRAIGHT LEG RAISING (sitting) (0-90° scale)

(Measure knee extension)

9.1 Left	_____ °	Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No	Location of Pain: <input type="checkbox"/> Back <input type="checkbox"/> Same Leg <input type="checkbox"/> Contralateral back/leg
9.2 Right	_____ °	Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No	Location of Pain: <input type="checkbox"/> Back <input type="checkbox"/> Same Leg <input type="checkbox"/> Contralateral back/leg

10. HIP AND SACROILIAC TESTS

10.1 Hip test pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Left <input type="checkbox"/> Right
10.2 Sacroiliac test pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Left <input type="checkbox"/> Right

11. STRAIGHT LEG RAISING (supine) (0-90° scale)

11.1 Left	_____ °	Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No	Location of Pain: <input type="checkbox"/> Back <input type="checkbox"/> Same Leg <input type="checkbox"/> Contralateral back/leg
11.2 Right	_____ °	Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No	Location of Pain: <input type="checkbox"/> Back <input type="checkbox"/> Same Leg <input type="checkbox"/> Contralateral back/leg

12. PULSES

		Left	Right
12.1 Dorsalis Pedis	_____ Present?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
12.2 Posterior tibial	_____ Present?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
12.3 Other observations (Clubbing, Cyanosis)	_____		

13. MUSCLE MEASUREMENT

13.1 Left Thigh	_____	Right Thigh	_____	_____ cm below tibial tubercle
13.2 Left Calf	_____	Right Calf	_____	_____ cm below tibial tubercle

14. LEG LENGTH EXAM

14.1 Symmetrical	Yes	No	Not Tested
14.2 Shorter	Left	Right	Supine <input type="checkbox"/> Standing <input type="checkbox"/>
Difference of	_____ cm	Right _____ cm	Left _____ cm

Supine: measure from anterior superior iliac spine to medial/lateral malleolus. **Standing:** measure from greater trochanter to floor

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15. OTHER TESTS AND FINDINGS _____

16. CLINICAL IMPRESSION OF SOMATIC AMPLIFICATION	SCORE
<p>SENSORY EXAMINATION: RESPONSE TO PINPRICK (check)</p> <p>16.1 No deficit or deficit well localized to dermatome(s) Deficit related to dermatome(s) but some inconsistency Nondermatomal or very inconsistent deficit Blatantly impossible(i.e., split down midline of entire body with positive tuning fork test)</p> <p>16.2 AMOUNT OF BODY INVOLVED (check) <15% 0 <input type="checkbox"/> 15-35% 1 <input type="checkbox"/> 36-60% 2 <input type="checkbox"/> >60% 3 <input type="checkbox"/></p>	
<p>MOTOR EXAMINATIONS (check)</p> <p>16.3 No deficit or deficit well localized to myotome(s) Deficit related to myotome(s) but some inconsistency Nonmyotomal or very inconsistent weakness, exhibits cogwheeling or giving away, weakness is coachable Blatantly impossible, significant weakness which disappears when distracted</p> <p>16.4 AMOUNT OF BODY INVOLVED (check) <15% 0 <input type="checkbox"/> 15-35% 1 <input type="checkbox"/> 36-60% 2 <input type="checkbox"/> >60% 3 <input type="checkbox"/></p>	
<p>TENDERNESS (check)</p> <p>16.5 No tenderness or tenderness localized to anatomically sensible structure Tenderness not well localized, some inconsistency Diffuse or inconsistent tenderness, multiple structures (skin, muscle, bone, etc.) Impossible, significant tenderness of multiple structures (skin, muscle, bone, etc.) which disappears when distracted</p> <p>16.6 AMOUNT OF BODY INVOLVED (check) <15% 0 <input type="checkbox"/> 15-35% 1 <input type="checkbox"/> 36-60% 2 <input type="checkbox"/> >60% 3 <input type="checkbox"/></p>	
<p>DIFFERENTIAL STRAIGHT LEG RAISING (SLR)</p> <p>16.7 The difference between SLR tests performed in the supine and sitting positions (the patient is distracted in the sitting position by examining the bottom of his/her feet). Example: supine SLR positive at 10°, seated SLR positive 50°, difference = 40° (check) Difference <20° 0 <input type="checkbox"/> 20-45° 1 <input type="checkbox"/> >45° 2 <input type="checkbox"/> No pain seated, but strongly positive SLR when supine at less than 45° 3 <input type="checkbox"/></p>	
TOTAL SCORE	

17. COMMENTS _____

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18. RADIOGRAPHIC EXAM Yes No Date _____ Type (Plain, CT, MRI, Myelogram) _____

Findings(Attach report if available): _____

Patient Position During X-ray: Recumbent Weight Bearing Unknown

19. CLINICAL DIAGNOSIS

(Please indicate appropriate ICD-9 code(s) and give written description. Generic diagnoses are printed for your convenience; you may substitute other diagnoses. If appropriate, multiple diagnoses can be designated.)

SOFT TISSUE

- Lumbar sprain/strain (847.2)
- Lumbosacral sprain/strain (846.0)
- Sacroiliac sprain/strain (846.1)

POSTERIOR JOINTS

- Facet syndrome (724.8)
- Lumbar subluxation (839.20) or segmented dysfunction (739.3) (circle)

DISC

- Lumbar disc displacement without myelopathy (with or without radiculitis) (722.10)
- Lumbosacral radiculitis (724.4)

SACROILIAC

- Sacroiliitis (720.2)
- Sacroiliac subluxation(839.42) or segmental dysfunction(739.4)(circle)

OTHER: _____

20. RECOMMENDATIONS, OPINION, REFERRALS, TX PLAN OR REDIRECTION: _____

21. AUTHORIZATION(S) REQUESTED FOR: _____

22. PHYSICIAN'S SIGNATURE _____ DATE _____

To Be Completed by Office Staff

Patient Name: _____
SSN: _____ - _____ - _____
Date of Injury: ____ / ____ / ____
Date of Birth: ____ / ____ / ____
Claim Number _____
Date of Exam: ____ / ____ / ____

Physician: _____
Address: _____
Phone: _____
FEIN: _____

PHYSICIAN MUST
SUBMIT THIS
FORM WITH LOW
BACK EXAM

TO BE COMPLETED BY PATIENT (ASSISTANCE PERMITTED)

Present History

1. What are your problems? _____

2. How did the problem occur? _____

3. Where is the location of the problem/pain? _____

4. Have you had this type of complaint before? Yes No
When?/ Where? _____

- 4.1 How did that earlier complaint occur?

5. What is the name of your employer?

- 5.1 What is the type of business of that company?

- 5.2 What was your job title when problem began?

- 5.3 What was your usual job? (Job Tasks)

- 5.4 Describe your job tasks. _____

- 5.5 What job were you performing when problem began?

6. Who is your immediate supervisor?

Name

Phone Number

7. Have you discussed your problem with your supervisor?
 Yes No
8. Is there modified or alternative work at your job?
 Yes No Don't Know
- 8.1 Are you now working? Yes No
- 8.2 If yes, employer _____
- 8.3 If yes, your job title _____
9. Your pain is worse in your:

<input type="checkbox"/> Head	<input type="checkbox"/> Left Arm	<input type="checkbox"/> Right Hip
<input type="checkbox"/> Neck	<input type="checkbox"/> Right Arm	<input type="checkbox"/> Left Leg
<input type="checkbox"/> Left Shoulder	<input type="checkbox"/> Back	<input type="checkbox"/> Right Leg
<input type="checkbox"/> Right Shoulder	<input type="checkbox"/> Left Hip	
<input type="checkbox"/> Other _____		
10. Your problem/pain is:

	No		
	Better	Worse	Different
When you urinate or move your bowels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When coughing or sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When you wake up in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the middle of the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mid-day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change of position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you been treated for this complaint before now?
 Yes No Where? _____
12. What has helped this complaint the most? _____
13. What has helped or made this complaint worse?

- 14.1 Do you get pain at the tip of your tailbone? Yes No
- 14.2 Does your whole leg ever become painful? Yes No
- 14.3 Does your whole leg ever go numb? Yes No
- 14.4 Does your whole leg ever give way? Yes No
- 14.5 In the past year, have you had any spells with very little pain? Yes No
- 14.6 Have you had any intolerance to your treatment or reaction to treatment? Yes No
- 14.7 Have you had an emergency room visit with back trouble since your recent work injury? Yes No

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Past History

15. Have you ever had a spine X-ray, CT scan, MRI or myelogram?
 X-ray Yes No
 When/Where/Results _____
 MRI Yes No
 When/Where/Results _____
 CT scan Yes No
 When/Where/Results _____
 Myelogram Yes No
 When/Where/Results _____
16. Have you ever been hospitalized for neck, arm, back, hip or leg complaints/pain? Yes No
 Which/When/Where _____
17. What other medical problems do you have?
 Heart, blood pressure, or circulation problems (circle)
 Diabetes Gout
 Arthritis Cancer
 Other _____
18. Have you been hospitalized for any of the above problems? Yes No
 Which/When _____
19. What medicines are you now taking, including over-the-counter?

20. Do you have a family doctor? Yes No
 Name: _____
 Phone No: _____
21. Allergies to food, medicine or other? Yes No
 List: _____

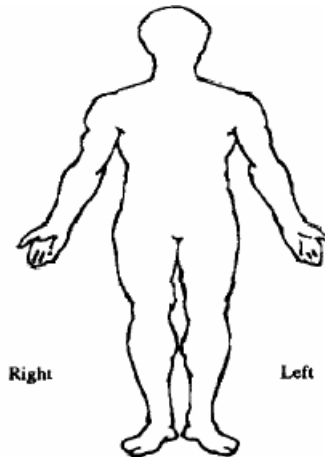
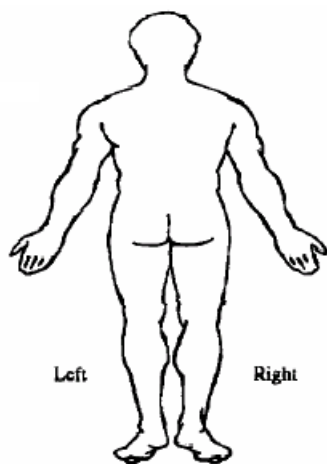
22. Do you smoke, rub, or chew tobacco? Yes No
23. Do you drink beer, wine or liquor? Yes No
 How Much? _____
- 23.1 Ever Have an alcohol problem? Yes No
24. Do you drink coffee or tea or caffeine drinks?
 Yes No How much per 24 hours? _____
25. How much formal education do you have?
 College or higher (specify) _____
 Vocational Training
 High School Diploma
 GED
 Grade Completed _____
26. Do you have other family members with serious back or neck Problems? Yes No
 Are they disabled? Yes No
27. Any additional comments:

Where is your pain? How does it feel? Draw your pain using the following key. Do not indicate areas of pain which are not related to your present injury or condition. Draw in your face:

BACK VIEW

FRONT VIEW

- KEY:**
- Stabbing / / /
- Burning X X X
- Pins O O O
And Needles
- Aching, ^ ^ ^
Throbbing
- Numbness = = =
- Other . . .



Signature of person completing form _____ Date _____
 If signature is not of patient, then state relationship to patient _____