Low Back Examination

Return completed application to the Third-Party Administrator
American Mining Claims Service
PO Box 660988
Birmingham, AL 35266-0988

USE BLACK INK To Be Completed by the Physician

| Patient Name: ________________________________ | Physician: ________________________________ |
| SSN: __ __ __ - __ __ - __ __ __ __          | Address: ________________________________   |
| Date of Injury: __ __ / __ __ / __ __        | Phone: ____________________________________ |
| Date of Birth: __ __ / __ __ / __ __           | FEIN: __ __ __ __ __ __ __ __ __ __ __ __ |
| Claim Number __ __ __ __ __ __ __ __   | Pulse: ____                                |
| Date of Exam: __ __ / __ __ / __ __          | BP: _____                                  |
|                                                   | Resp. _____                                |

PLEASE CHECK ONE OR MORE:
☐ CLAIM REOPENING ☐ IMPAIRMENT RATING ☐ 120-DAY EXAMINATION
☐ CONSULTATION ☐ INDEPENDENT EXAMINATION ☐ COMPREHENSIVE EXAMINATION

1. **INSPECTION** (standing)

   1.1 Patient stands unassisted ☐ ☐ __________________________
   1.2 Scoliosis ☐ ☐ __________________________
   1.3 Antalgic lean(Asymmetry) ☐ ☐ __________________________
   1.4 Lumbar Hypolordosis ☐ ☐ __________________________
   1.5 Lumbar Hyperlordosis ☐ ☐ __________________________
   Other observations __________________________

2. **PALPATION** (standing, seated, or prone)

   2.1 Vertebral tenderness/restriction ☐ ☐ ☐ L1 ☐ L2 ☐ L3 ☐ L4 ☐ L5
   2.2 Coccyx tenderness (external palpation) ☐ ☐ __________________________
   2.3 Sacral base & pelvis level (standing) ☐ ☐ __________________________
   2.4 Paraspinal muscle tenderness ☐ ☐ ☐ ☐ __________________________
   2.5 Paraspinal muscle spasm ☐ ☐ ☐ ☐ __________________________
   2.6 Sacroiliac joint tenderness ☐ ☐ ☐ ☐ __________________________

3. **GAIT**

   3.1 Limp ☐ Yes ☐ No ☐ Left ☐ Right ☐ Explain __________________________
   3.2 Assistive devices (cane, brace, prosthesis) __________________________
   3.3 Other observations __________________________

4. **SQUAT**

   4.1 Squats fully and rises without difficulty ☐ Yes ☐ No __________________________
   Comments __________________________

5. **RANGE OF MOTION** (standing)*

   5.1 Sacral Flexion ° ☐ ☐ ☐ ☐
   5.2 Sacral Extension ° ☐ ☐ ☐ ☐
   5.3 Forward bending(Flexion) ° ☐ ☐ ☐ ☐
   5.4 Backward bending(Extension) ° ☐ ☐ ☐ ☐
   5.5 Left side bending ° ☐ ☐ ☐ ☐
   5.6 Right side bending ° ☐ ☐ ☐ ☐
   5.7 Comments __________________________
   5.8 Inclinometer ☐ Yes ☐ No (Inclinometer required for impairment examinations)

*NOTE: Subtract sacral motions from T12 motions(pp.3/126-129 AMA Guides, 4th ed.)

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**RANGE OF MOTION CERTIFICATION**
Thoracolumbar motion testing is valid if the following four criteria are achieved. Please certify the status of the examinee on each of these four criteria:
• The back injury is now stable. ☐ Yes ☐ No
• The motions were not curtailed due to a report of pain, fear of injury, or neuromuscular inhibition. ☐ Yes ☐ No
• Three consecutive measurements of each motion were within 5° (within 10° if the three averaged 50° or more) ☐ Yes ☐ No
• Examinee passed validity test ☐ Yes ☐ No

Physician’s Signature
Source: AMA Guides to the Evaluation of Permanent Impairment, pp. 112 & 127.
6. **MOTOR STRENGTH** (standing, walking, seated, or supine) **GRADE (OUT OF 5)**

<table>
<thead>
<tr>
<th></th>
<th>NORMAL</th>
<th>ABNORMAL</th>
<th>LEFT</th>
<th>RIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Hip flexion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.2 Hip extension</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.3 Hip abduction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.4 Knee extension</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.5 Knee flexion</td>
<td></td>
<td></td>
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<tr>
<td>6.6 Ankle dorsiflexion</td>
<td></td>
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<td></td>
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<tr>
<td>6.7 Ankle planter flexion</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>6.8 Great toe extension</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>6.9 Heel toe walk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.0 Toe walk</td>
<td></td>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>LEFT</th>
<th>RIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Normal</td>
<td>Diminished</td>
</tr>
<tr>
<td>7.1 L3 sensory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.2 L4 sensory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.3 L5 sensory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.4 S1 sensory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.5 Comments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. **REFLEXES** (seated) (**+2 normal**)

- **Patellar**
  - 8.1 Left: □ 0 □ +1 □ +2 □ +3 □ clonus
  - 8.2 Right: □ 0 □ +1 □ +2 □ +3 □ clonus
- **Achilles**
  - 8.3 Left: □ 0 □ +1 □ +2 □ +3 □ clonus
  - 8.4 Right: □ 0 □ +1 □ +2 □ +3 □ clonus
- **Other**

9. **STRAIGHT LEG RAISING** (sitting) (**0-90° scale**) (Measure knee extension)

<table>
<thead>
<tr>
<th></th>
<th>Left</th>
<th>Right</th>
<th>Pain:</th>
<th>Yes</th>
<th>No</th>
<th>Location of Pain:</th>
<th>Back</th>
<th>Same Leg</th>
<th>Contralateral back/leg</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>9.2</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

10. **HIP AND SACROILIAC TESTS**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Left</th>
<th>Right</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1</td>
<td></td>
<td></td>
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<tr>
<td>10.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. **STRAIGHT LEG RAISING** (supine) (**0-90° scale**) (Measure knee extension)

<table>
<thead>
<tr>
<th></th>
<th>Left</th>
<th>Right</th>
<th>Pain:</th>
<th>Yes</th>
<th>No</th>
<th>Location of Pain:</th>
<th>Back</th>
<th>Same Leg</th>
<th>Contralateral back/leg</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>11.2</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

12. **PULSES**

<table>
<thead>
<tr>
<th></th>
<th>Left</th>
<th>Right</th>
<th>Present?</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.3</td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

13. **MUSCLE MEASUREMENT**

<table>
<thead>
<tr>
<th></th>
<th>Left Thigh</th>
<th>Right Thigh</th>
<th>cm below tibial tubercle</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14. **LEG LENGTH EXAM**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not Tested</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Difference of</th>
<th>cm</th>
<th>Right</th>
<th>cm</th>
<th>Left</th>
<th>cm</th>
<th>Supine:</th>
<th>measure from anterior superior iliac spine to medial/lateral malleolus.</th>
<th>Standing:</th>
<th>measure from greater trochanter to floor</th>
</tr>
</thead>
</table>
15. OTHER TESTS AND FINDINGS

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

16. CLINICAL IMPRESSION OF SOMATIC AMPLIFICATION

<table>
<thead>
<tr>
<th>SENSORY EXAMINATION: RESPONSE TO PINPRICK</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.1 No deficit or deficit well localized to dermatome(s)</td>
<td>(check)</td>
</tr>
<tr>
<td>Deficit related to dermatome(s) but some inconsistency</td>
<td></td>
</tr>
<tr>
<td>Nondermatomal or very inconsistent deficit</td>
<td></td>
</tr>
<tr>
<td>Blatantly impossible (i.e., split down midline of entire body with positive tuning fork test)</td>
<td></td>
</tr>
</tbody>
</table>

16.2 AMOUNT OF BODY INVOLVED (check)

- <15% 0
- 15-35% 1
- 36-60% 2
- >60% 3

16.3 MOTOR EXAMINATIONS

16.4 AMOUNT OF BODY INVOLVED (check)

- <15% 0
- 15-35% 1
- 36-60% 2
- >60% 3

16.5 TENDERNESS

16.6 AMOUNT OF BODY INVOLVED (check)

- <15% 0
- 15-35% 1
- 36-60% 2
- >60% 3

16.7 DIFFERENTIAL STRAIGHT LEG RAISING (SLR)

- Difference <20° 0
- 20-45° 1
- >45° 2

No pain seated, but strongly positive SLR when supine at less than 45° 3

TOTAL SCORE

17. COMMENTS

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
Patient’s Name__________________________________ Date of Exam _______________ Claim Number __ __ __ __ __ __ __ __ __

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
☐ 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)

☑ OTHER: __________________________________________________________
____________________________________________________________________________________

POSTERIOR JOINTS
☐ Lumbar subluxation (839.20) or segmented dysfunction (739.3) (circle)

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

20. RECOMMENDATIONS, OPINION, REFERRALS, TX PLAN OR REDIRECTION: _______________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

21. AUTHORIZATON(S) REQUESTED FOR: __________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

22. PHYSICIAN’S SIGNATURE ________________________________ DATE__________
### Patient History – Back Pain

**To Be Completed by Office Staff**

- **Patient Name:** ____________________________________
- **SSN:** __ __ __ - __ __ - __ __ __ __
- **Date of Injury:** __ __ / __ __ / __ __
- **Date of Birth:** __ __ / __ __ / __ __
- **Claim Number:** __ __ __ __ __ __ __ __
- **Date of Exam:** __ __ / __ __ / __ __
- **Physician:** _____________________________________
- **Address:** _____________________________________
- **Phone:** _____________________________________
- **FEIN:** __ __ __ __ __ __ __ __ __ __ __ __

**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:**
   - Head
   - Left Arm
   - Right Hip
   - Neck
   - Right Arm
   - Left Leg
   - Left Shoulder
   - Back
   - Right Leg
   - Right Shoulder
   - Left Hip
   - Other

10. **Your problem/pain is:**
   - Better
   - Worse
   - Different
   
   When you urinate or move your bowels
   When coughing or sneezing
   When you wake up in the morning
   In the middle of the night
   Mid-day
   Evening
   Lying
   Sitting
   Driving
   Bending
   Standing
   Walking
   Change of position

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. Do you get pain at the tip of your tailbone?  
   - Yes
   - No

14.1 Does your whole leg ever become painful?  
   - Yes
   - No

14.2 Does your whole leg ever go numb?  
   - Yes
   - No

14.3 Does your whole leg ever give way?  
   - Yes
   - No

14.4 In the past year, have you had any spells with very little pain?  
   - Yes
   - No

14.5 Have you had any intolerance to your treatment or reaction to treatment?  
   - Yes
   - No

14.6 Have you had an emergency room visit with back trouble since your recent work injury?  
   - Yes
   - No
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?

24. Have you been hospitalized for any of the above problems? [ ] Yes [ ] No
    Which/When __________________________________

25. What other medical problems 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 __________________________________________