

Workers' Compensation Low Back Examination

Please return completed application to the applicable entity regarding this claim.
(Private Carrier, Self-Insured, or Third Party Administrator (TPA) administering this claim)

USE BLACK INK

To Be Completed by the Physician

Page 1

Patient Name: _____ SSN: ____ - ____ - _____ HT. _____ Date of Injury: ____ / ____ / ____ WT. _____ Date of Birth: ____ / ____ / ____ Pulse _____ Claim Number _____ BP _____ Date of Exam: ____ / ____ / ____ Resp. _____	Physician: _____ Address: _____ _____ Phone: _____ FEIN: _____
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PLEASE CHECK ONE OR MORE:

<input type="checkbox"/> CLAIM REOPENING	<input type="checkbox"/> IMPAIRMENT RATING	<input type="checkbox"/> 120-DAY EXAMINATION
<input type="checkbox"/> CONSULTATION	<input type="checkbox"/> INDEPENDENT EXAMINATION	<input type="checkbox"/> COMPREHENSIVE EXAMINATION

1. INSPECTION (*standing*)

	YES	NO	
1.1 Patient stands unassisted	<input type="checkbox"/>	<input type="checkbox"/>	_____
1.2 Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
1.3 Antalgic lean (<i>Asymmetry</i>)	<input type="checkbox"/>	<input type="checkbox"/>	_____
1.4 Lumbar Hypolordosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
1.5 Lumbar Hyperlordosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other observations: _____

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

	YES	NO	
2.1 Vertebral tenderness/restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> L1 <input type="checkbox"/> L2 <input type="checkbox"/> L3 <input type="checkbox"/> L4 <input type="checkbox"/> L5
2.2 Coccyx tenderness (external palpation)	<input type="checkbox"/>	<input type="checkbox"/>	_____
2.3 Sacral base & pelvis level (standing)	<input type="checkbox"/>	<input type="checkbox"/>	_____

	LEFT		RIGHT		
	YES	NO	YES	NO	
2.4 Paraspinal muscle tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2.5 Paraspinal muscle spasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2.6 Sacroiliac joint tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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)* **WNL PAIN RESTRICTION**

5.1 Sacral Flexion	___°	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.2 Sacral Extension	___°	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.3 Forward bending (<i>Flexion</i>)	___°	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.4 Backward bending (<i>Extension</i>)	___°	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.5 Left side bending	___°	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.6 Right side bending	___°	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.7 Comments _____				
5.8 Inclinometer <input type="checkbox"/> Yes <input type="checkbox"/> No (Inclinometer required for impairment examinations)				

**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.

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

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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12.2 Posterior tibial	_____ Present?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Tested
14.2 Shorter	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Supine <input type="checkbox"/> Standing
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

15. OTHER TESTS AND FINDINGS _____

16. CLINICAL IMPRESSION OF SOMATIC AMPLIFICATION

SCORE _____

SENSORY EXAMINATION: RESPONSE TO PINPRICK

(check)

- 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*)

16.2 AMOUNT OF BODY INVOLVED

(check)

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

MOTOR EXAMINATIONS

(check)

- 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

16.4 AMOUNT OF BODY INVOLVED

(check)

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

TENDERNESS

(check)

- 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

16.6 AMOUNT OF BODY INVOLVED

(check)

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

DIFFERENTIAL STRAIGHT LEG RAISING (SLR)

- 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 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-10 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** _____

Workers' Compensation Patient History – Back Pain

USE BLACK INK

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To Be Completed by Office Staff

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

PHYSICIAN MUST
SUBMIT THIS
FORM WITH LOW
BACK 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 the 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:

	Better	Worse	No 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

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

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 had 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

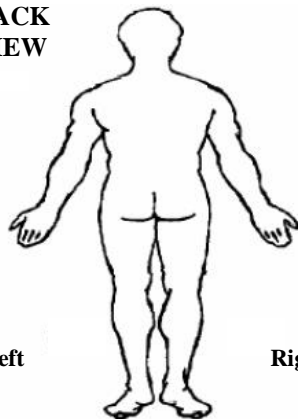
Are they disabled? Yes No

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:**

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

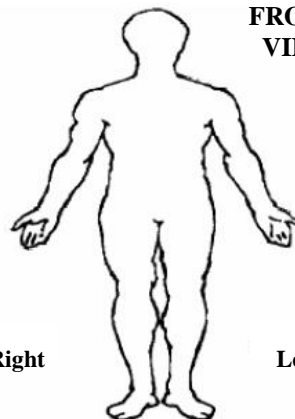
BACK VIEW



Left

Right

FRONT VIEW



Right

Left

Signature of person completing form _____ Date _____

If signature is not of patient, then state relationship to patient _____