Lower Back Pain Exam

Patient Last Name ______________________**First Name** ________________**MI**____**DOB**______________________
Address________________________________**City**_____________________________**State**_________**Zip**__________
Preferred Care ID Number _______________**Dr. Last Name**_______________ **First Name**______________**MI**____
Injury/Illness related to: ☐work ☐auto ☐other

History:
Onset: ____

Provocative:____

Palliative: ____

Quality:____

Radiation/Location:____

Past History:____

Wt: __________ **Ht:**__________ **BP:**_____/____ **Pulse:**______**bpm; reg / irreg** **Age:**_________

Th/LumROM	Normal	Exam	Pain		Right	Left
Flexion	90°			Heel/Toe Rise(L4,L5/L5,S1)		
Extension	30°			Babinski sign	Present/Absent	Present/Absent
R Lat'l Flx	30°			Rhomberg's		
L Lat'l Flx	30°			Kemp's Standing	Neg/Local pain /Radiate	Neg/Local pain /Radiate
R Rot'n	30°			Adam's Standing		
L Rot'n	30°			Gillet's		

DTR's (0-5)	Right	Left	Dermatome (pinwheel)	Right	Left	Motor Strength (0-5)	Right	Left
C5 (biceps)			L1 (Upp thigh)			L1		
C6 (brachiorad)			L2 (Mid thigh)			L2		
C7 (triceps)			L3 (Lower thigh)			L3 (Thigh Adductors)		
L4 (patella)			L4 (Medial leg/foot)			L4 (Tib ant'r)		
L5 (med Hamstr)			L5 (Lat'l leg/dorsal foot)			L5 (EHL/Ext dig long./Glut Med)		
S1 (Achilles)			S1 (Lat'l foot/heel cord)			S1 (Peronei/ Tri Surae/Glut max)		

Exam/Maneuver	Right	Left	Review of Systems	
Valsalva			☐ N Cardiovascular	☐ Y
SLR			☐ N Musculoskeletal	☐ Y
SLR w/ ankle dors.			☐ N Respiratory	☐ Y
FAbERE/ Patrick			☐ N Neurological	☐ Y
Yeoman's			☐ N Dermatological	☐ Y
Spasm / TTP: Level(s)			☐ N GI	☐ Y
			☐ N GU	☐ Y
			☐ N Endocrine	☐ Y

Dx:
- ☐ 847.2 Sprain/St
- ☐ 724.8 Facet Syn
- ☐ 847.3 SI Sp/St
- ☐ 724.4 IntCostN
- ☐ 722.2 IVD Syn
- ☐ 722.52 DJD
- ☐ 724.02 Stenosis
- ☐ 756.1 Spondy
- ☐ 739.3 Lsubux
- ☐ 724.3 Sciatic N.
- ☐ Other_________

Pain intensity according to patient None 0 1 2 3 4 5 6 7 8 9 10 Severe

Primary Diagnosis: __________________ ☐☐☐☐☐☐☐☐☐☐☐
Secondary Diagnosis:_________________ ☐☐☐☐☐☐☐☐☐☐☐
Outcome Assessment Tool:_______________________________________ **Score: 1st Visit** _______**8th Visit** ______________
Current Treatment Plan w/Goals:____

Proposed Treatment Plan: From: ______/______/______ **To:** _____/_____/______**Number of visits Requested:** ___________

_________________________________ _________________________________
Doctor's Signature **Date**