encova INSURANCE

LOW BACK EXAMINATION

Return completed form to:
Encova Insurance
P.O. Box 3151
Charleston, WV 25332-3151

TO BE COMPLETED BY THE PHYSICIAN.

USE BLACK INK

Patient name		Physician
Social Security number	Height	Address
Date of injury	Weight	
Date of birth	Pulse	
Claim number	BP	Phone
Date of exam	Resp.	FEIN

Please check one or more:

- ☐ Claim reopening
- ☐ Consultation
- ☐ Impairment rating
- ☐ Independent examination
- ☐ 120-day examination
- ☐ Comprehensive examination

1. Inspection (standing)

	Yes	No	
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, seating or prone)

	Yes	No					
2.1 Vertebral tenderness/restriction	☐	☐	☐ L1	☐ L2	☐ L3	☐ L4	☐ L5
2.2 Coccyx tenderness (external palpation)	☐	☐					
2.3 Sacral base and pelvis level (standing)	☐	☐					

	Left		Right		
	Yes	No	Yes	No	
2.4 Paraspinal muscle tenderness	◯	◯	◯	◯	
2.5 Paraspinal muscle spasm	◯	◯	◯	◯	
2.6 Sacroiliac joint tenderness	◯	◯	◯	◯	

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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	°	☐	☐	
5.2 Sacral extension	°	☐	☐	
5.3 Forward bending (flexion)	°	☐	☐	
5.4 Backward bending (extension)	°	☐	☐	
5.5 Right side bending	°	☐	☐	
5.6 Left 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.)

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 motionwere within 5° (within 10° if the three averaged 50° or more).
☐ Yes ☐ No

Examinee passed validity test.
☐ Yes ☐ No

Physician signature

Source: AMA Guides to the Evaluation of Permanent Impairment, pp. 112 & 127

6. Motor strength (standing, walking, seated or supine)

	Normal	Abnormal	Grade (out of 5) Left	Right
6.1 Hip flexion	☐	☐		
6.2 Hip extension	☐	☐		
6.3 Hip abduction	☐	☐		
6.4 Knee extension	☐	☐		
6.5 Knee flexion	☐	☐		
6.6 Ankle dorsiflexion	☐	☐		
6.7 Ankle plantar flexion	☐	☐		
6.8 Great toe extension	☐	☐		
6.9 Heel toe walk	☐	☐		
6.0 Toe walk	☐	☐		

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

	Left			Right		
	Normal	Diminished	Absent	Normal	Diminished	Absent
7.1 L3 sensory	☐	☐	☐	☐	☐	☐
7.2 L4 sensory	☐	☐	☐	☐	☐	☐
7.3 L5 sensory	☐	☐	☐	☐	☐	☐
7.4 S1 sensory	☐	☐	☐	☐	☐	☐

7.5 Comments

8. Reflexes (seated) (+2normal)

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)

9.1 Left _____ ° Pain ☐ Yes ☐ No Location of pain ☐ Back ☐ Same leg ☐ Contralateral back/leg

9.2 Right _____ ° Pain ☐ Yes ☐ No Location of pain ☐ Back ☐ Same leg ☐ Contralateral back/leg

10. Hip and sacroiliac tests

10.1 Hip test pain ☐ Yes ☐ No ☐ Left ☐ Right

10.2 Sacroiliac test pain ☐ Yes ☐ No ☐ Left ☐ Right

11. Straight leg raising (supine) (0-90° scale)

11.1 Left _____ ° Pain ☐ Yes ☐ No Location of pain ☐ Back ☐ Same leg ☐ Contralateral back/leg

11.2 Right _____ ° Pain ☐ Yes ☐ No Location of pain ☐ Back ☐ Same leg ☐ Contralateral back/leg

12. Pulses

	Left		Right	
12.1 Dorsalis pedis	Present? ☐ Yes	☐ No	Present? ☐ Yes	☐ No
12.2 Posterior tibial	Present? ☐ Yes	☐ No	Present? ☐ Yes	☐ No

12.3 Other observations (clubbing, cyanosis)

13. Muscle measurement

13.1 Left thigh _____ Right thigh _____ _____ cm above patella

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 ◯ 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.

Patient name	Date of exam	Claim number

USE BLACK INK

15. Other tests and findings

16. Clinical impression of somatic amplification	Check	Score
Sensory examination: response to pinprick		
16.1 No deficit or deficit well localized to dermatome(s)	☐ 0	
Deficit related to dermatome(s) but some inconsistency	☐ 1	
Nondermatomal or very inconsistent deficit	☐ 2	
Blatantly impossible (i.e., split down midline of entire body with positive tuning fork test)	☐ 3	0
16.2 Amount of body involved ☐ <15% **0** ☐ 15-35% **1** ☐ 36-60% **2** ☐ >60% **3**		0
Motor examinations		
16.3 No deficit or deficit well localized to myotome(s)	☐ 0	
Deficit related to myotome(s) but some inconsistency	☐ 1	
Nonmyotomal or very inconsistent weakness, exhibits cogwheeling or giving away, weakness is coachable	☐ 2	
Blatantly impossible, significant weakness which disappears when distracted	☐ 3	0
16.4 Amount of body involved ☐ <15% **0** ☐ 15-35% **1** ☐ 36-60% **2** ☐ >60% **3**		0
Tenderness		
16.5 No tenderness or tenderness localized to anatomically sensible structure	☐ 0	
Tenderness not well localized, some inconsistency	☐ 1	
Diffuse or inconsistent tenderness, multiple structures (skin, muscle, bone, etc.)	☐ 2	
Impossible, significant tenderness of multiple structures (skin, muscle, bone, etc.) which disappears when distracted	☐ 3	0
16.6 Amount of body involved ☐ <15% **0** ☐ 15-35% **1** ☐ 36-60% **2** ☐ >60% **3**		0
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°		
Difference ☐ <20° **0** ☐ 20-45° **1** ☐ >45° **2**		
☐ No pain seated, but strongly positive SLR when supine at less than 45° **3**		0
	Total	0

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 diagnosis codes and give written description. If appropriate, multiple diagnoses can be designated.)

Soft tissue

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

Disc

Lumbar disc displacement without:

- ☐ Myelopathy (with or without radiculitis) (722.10)
- ☐ Lumbosacral radiculitis (724.4)

Other

Posterior joints

- ☐ Facet syndrome (724.8)
- ☐ 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. Authorization(s) requested for

Physician signature	Date

PATIENT HISTORY BACK PAIN

Physician must submit this form with low back exam.
To be completed by physician's staff.

Patient name		Physician
Social Security number	Height	Address
Date of injury	Weight	
Date of birth	Pulse	
Claim number	BP	Phone
Date of exam	Resp.	FEIN

PRESENT HISTORY

Please complete the form in black ink.

TO BE COMPLETED BY PATIENT (ASSISTANCE PERMITTED)

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 and 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 ☐ Dont 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 ☐ Neck ☐ Right hip ☐ Left hip
☐ Right arm ☐ Left arm ☐ Left shoulder ☐ Right shoulder
☐ Back ☐ Left leg ☐ Right leg ☐ Other:

10. Your problem/pain is	Better	Worse	No 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?

14.1 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 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

When/where/results

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 number

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

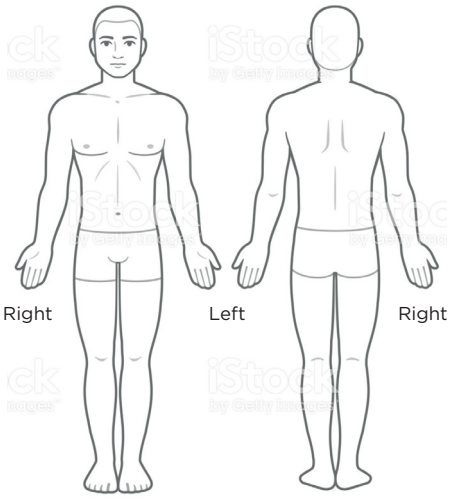
☐ Grade completed:

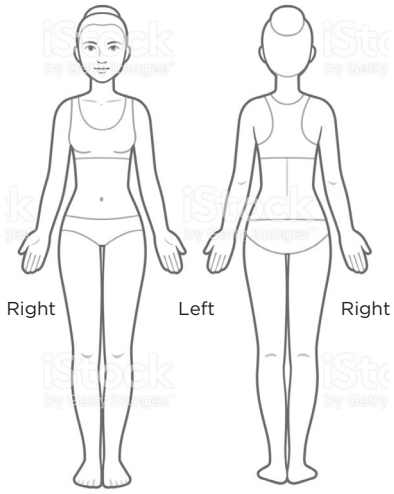
26. Do you have other family members with serious back or neck problems? ☐ Yes ☐ No

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.





KEY

Stabbing	/ / /
Burning	X X X
Pins and needles	O O O
Aching, throbbing	^ ^ ^
Numbness	= = =
Other	• • •

Signature of person completing form	Date

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