

Patient ID _____
Physician ID _____
Site/Clinic ID _____
(0.0.0, 104.52, 104.53)

# PHYSICIAN BASELINE EXAMINATION AND DIAGNOSIS NON-SURGICAL/SURGICAL CARE LOW BACK PAIN FORM 6.2

DATE OF PATIENT VISIT: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
month                      day                      year

104.215

1. PATIENTS CHIEF COMPLAINT (check all that apply):

104.351

	Pain	Numbness/ Dysethesia	Weakness
a. Lower back .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Left leg .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Right leg .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. PREVIOUS LOW BACK SURGERY (check one box):

104.1208

- a. None (Skip to question 4) .....
- b. One .....
- c. Two .....
- d. Three .....
- e. Four or more .....

3. TYPE OF PREVIOUS BACK SURGERY (check all that apply):

104.354

3a. UNKNOWN .....

3b.	L1,2	L2,3	L3,4	L4,5	L5,S1	Unknown
a. FUSION .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. LAMINECTOMY (for decompression) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. CHYMOPAPAIN INJECTIONS .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. PERCUTANEOUS LUMBAR DISCECTOMY .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. MICROSCOPIC DISCECTOMY .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. ARTHROSCOPIC DISCECTOMY .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. LASER DISCECTOMY .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3c. LAMINOTOMY (DISCECTOMY) (check all that apply):

100.1228

	Right					Left					Unknown
	L1,2	L2,3	L3,4	L4,5	L5,1	L1,2	L2,3	L3,4	L4,5	L5,1	
a. With discectomy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Without discectomy ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. With foraminotomy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Without foraminotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Facetectomy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. ANKLE REFLEXES (check one for each row):

100.747

	None (0)	Less Than Normal (+ 1)	Normal (+ 2 + 3)	More Than Normal (+ 4 + 5)	Not Done
a. Right .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Left .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. KNEE REFLEXES (check one for each row):

100.749

	None (0)	Less Than Normal (+ 1)	Normal (+ 2 + 3)	More Than Normal (+ 4 + 5)	Not Done
a. Right .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Left .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. IS ALL MUSCLE STRENGTH NORMAL?

Yes       No

104.428

7. ARE ALL SENSORY FINDINGS NORMAL?

Yes       No

104.429

8. PHYSICIAN DISCREPANCY FACTOR

(Observed patient behavior does not correspond with patient report of symptoms)

Positive       Negative

104.430

9. Do test results correlate with clinical findings? (check all that apply):

100.1216

	Yes	No	Not Done
a. CT .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. MRI .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Spine Films .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Bone Scan .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Myelogram .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. MOST LIKELY DIAGNOSIS BASED ON CURRENTLY AVAILABLE INFORMATION?  
 (check one box in each column):

	Primary Diagnosis	Secondary Diagnosis
a. Lumbar strain or sprain .....	<input type="checkbox"/>	<input type="checkbox"/>
b. Degenerative disc and joint disease .....	<input type="checkbox"/>	<input type="checkbox"/>
c. Disc herniation without radiculopathy .....	<input type="checkbox"/>	<input type="checkbox"/>
d. Disc herniation with radiculopathy .....	<input type="checkbox"/>	<input type="checkbox"/>
e. Stenosis .....	<input type="checkbox"/>	<input type="checkbox"/>
f. Non-degenerative spondylolisthesis/spondylolysis .....	<input type="checkbox"/>	<input type="checkbox"/>
g. Degenerative spondylolisthesis/spondylolysis .....	<input type="checkbox"/>	<input type="checkbox"/>
h. Neoplastic disease .....	<input type="checkbox"/>	<input type="checkbox"/>
i. Inflammatory spondyloarthropathy .....	<input type="checkbox"/>	<input type="checkbox"/>
j. Fracture .....	<input type="checkbox"/>	<input type="checkbox"/>
k. Non-specific low back pain .....	<input type="checkbox"/>	<input type="checkbox"/>
l. Lumbar instability .....	<input type="checkbox"/>	<input type="checkbox"/>
m. Other .....	<input type="checkbox"/>	<input type="checkbox"/>

104.435