



THERAPRACTICS BACK EVALUATION

PATIENT: _____ DATE: _____

PATIENT #: _____ EMPLOYER: _____

DIAGNOSIS: _____ PHYSICIAN: _____

SUBJECTIVE HISTORY

AGE: ___ D.O.B. _____ SEX: ___ OCCUPATION: _____ DATE OF INJURY: _____

MECHANISM OF INJURY: _____

GENERAL HEALTH: _____

PERTINENT SURGERIES / DATES: _____

MEDICATIONS: _____

PREVIOUS HISTORY / TREATMENT: _____

CHIEF COMPLAINT: _____

NATURE OF SYMPTOMS:

_____ intermittent	_____ constant
_____ sharp	_____ achy / dull
_____ radiating	_____ localized
_____ throbbing	_____ numbness / tingling

SYMPTOMS ARE GETTING: _____ better _____ worse _____ stable

PAIN (0 – 10 scale, 0 = no pain): _____ now _____ at worst _____ at best

PAIN AGGRAVATED BY:

_____ bending	_____ sitting	_____ standing
_____ walking	_____ lying	_____ other _____

PAIN EASED BY:

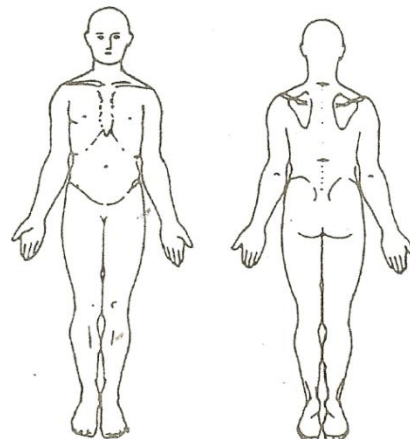
_____ bending	_____ sitting	_____ standing
_____ walking	_____ lying	_____ other _____

DISTURBED SLEEP: ___ YES ___ NO COUGH / SNEEZE: _____ ve

PRIOR TO THIS EPISODE, THE PATIENT WAS COMPLETELY FREE OF
LOW BACK SYMPTOMS: ___ YES ___ NO SYMPTOMS NOW: ___ YES ___ NO

OBJECTIVE (Posture categories unchecked indicate WNL)

POSTURE: Lateral View: Fwd head/shlds C/S lordosis ___ Hypo ___ Hyper T/S kyphosis ___ Hypo ___ Hyper
 L/S lordosis ___ Hypo ___ Hyper Knees ___ Fwd ___ Back Body Lean ___ Fwd ___ Back Abdom. ___ Protuberant
Posterior View: Head tilt ___ (R) ___ (L) Shld/Scap high ___ (R) ___ (L) C/S Curve ___ (R) ___ (L)
 T/S Curve ___ (R) ___ (L) L/S Curve ___ (R) ___ (L) Iliac Crest High ___ (R) ___ (L) Genu ___ Varus ___ Valgus
 Achilles Tendon Bow ___ Inward ___ Outward Arm rotation ___ Internal ___ External



++++ Numbness
 #### Major Pain
 //// Associated Pain
 ↓ ↑ Radiating Pain

T/L SPINE R.O.M. & STRENGTH (* = Pain)

T/L SPINE MOTIONS (Est. Normal)	R.O.M.	STRENGTH
FORWARD BEND (90°)	°	/5
BACKWARD BEND (30°)	°	/5
SIDE BEND RIGHT (30°)	°	/5
SIDE BEND LEFT (30°)	°	/5
ROTATION RIGHT (30°)	°	/5
ROTATION LEFT (30°)	°	/5

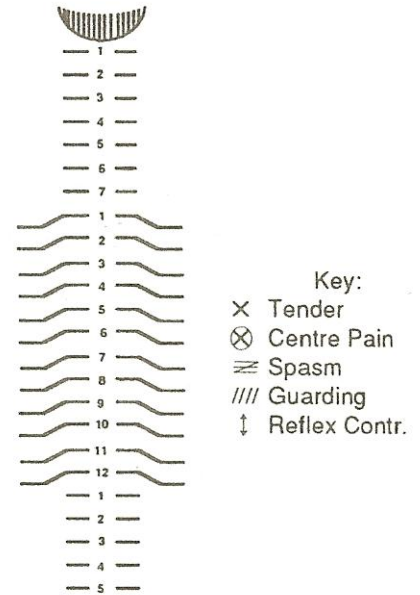
STRENGTH	RIGHT	LEFT
L 1, 2 Psoas	/5	/5
L 3 Quads	/5	/5
L 4 Ant. Tib.	/5	/5
L 5 E.H.L.	/5	/5
S 1 F.H.L.	/5	/5
S 2 Hamstring	/5	/5

REFLEXES	RIGHT	LEFT
L4 Knee Jerk		
S 1 Ankle Jerk		

Key: 0 = Absent 1+ = Diminished
2+ = Normal 3+ = Increased 4+ = Clonus

	RIGHT	LEFT
S.I. Jt. Compression	<input type="checkbox"/> Pos <input type="checkbox"/> Neg.	<input type="checkbox"/> Pos <input type="checkbox"/> Neg.
S.I. Jt. Gapping	<input type="checkbox"/> Pos <input type="checkbox"/> Neg.	<input type="checkbox"/> Pos <input type="checkbox"/> Neg.
F.A.B.E.R.E.	<input type="checkbox"/> Pos <input type="checkbox"/> Neg.	<input type="checkbox"/> Pos <input type="checkbox"/> Neg.
S.L.R.	<input type="checkbox"/> Pos <input type="checkbox"/> Neg. at ____°	<input type="checkbox"/> Pos <input type="checkbox"/> Neg. at ____°
Seated S.L.R.	<input type="checkbox"/> Pos <input type="checkbox"/> Neg. at ____°	<input type="checkbox"/> Pos <input type="checkbox"/> Neg. at ____°

PALPATION/CONDITION:



PALPATION: _____

FUNCTIONAL STATUS: _____

GAIT DEVIATIONS: _____

MAJOR PROBLEMS: 1. Pain Swelling Spasm _____

2. Decreased: ROM/Flexibility _____ Strength _____

3. Postural Deficits _____

GOALS: 1. Decrease: Pain Swelling Spasm _____

2. Increase: ROM/Flexibility _____ Strength _____

3. Improve Posture _____

PLAN: 1. Therapeutic Exercises _____

2. Soft Tissue Mobilization Joint Mobilization _____

3. Modalities PRN for: Pain Swelling Spasm control _____

FREQUENCY: _____ **DURATION:** _____

_____ R.P.T., D.C.