CVH-462 **CONNECTICUT VALLEY HOSPITAL**
New 7/99 **PHYSICAL THERAPY**
SPINAL EVALUATION- Lumbar Spine

[ ] General Psychiatry Division
[ ] Whiting Forensic Division
[ ] Addiction Services Division

Name _____

MPI#_____*Print or Addressograph*

Ward/Unit_____ Date of Admission_____ Date of Birth_____ Age_____

Treating Diagnosis/Chief Complaint:_____

History of Back Problems:_____

Prior Spinal Surgery:_____

Past Medical History:_____

Anticipated Occupation upon Discharge:_____

Hand Dominance: [ ] Left [ ] Right Height: _____ Weight: _____ BMI:_____

Posture: [ ] Lateral Shift Left/Right [ ] Increased Lumbar Lordosis [ ] Pelvic Asymmetry

Comments:_____

Function: Toe Walking (S1-S2): [ ] normal [ ] weak [ ] unable
Heel Walking (L4-S1): [ ] normal [ ] weak [ ] unable

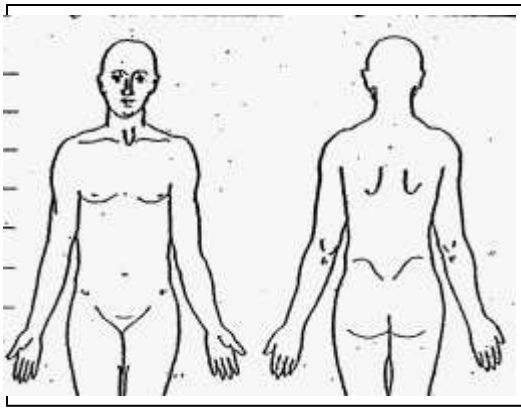
Range of Motion: *(limited/WNL)*	Active		Passive		Comments- *(indicate degrees, end feel)*
	Left	Right	Left	Right	
Lumbar Flexion					
Lumbar Extension					
Lumbar sidebending to the left					
Lumbar sidebending to the right					
Lumbar Rotation to the left					
Lumbar Rotation to the right					
Hamstring Flexibility					

Thoracic Spine: [ ] WNL [ ] Limited: _____
Cervical Spine: [ ] WNL [ ] Limited: _____

Strength:	Strong & Painfree		Strong & Painful		Weak & Painfree		Weak & Painful	
	Left	Right	Left	Right	Left	Right	Left	Right
Hip Flexion (L1-L4)								
Knee Flexion (L2-L4)								
Great Toe Extension (L5)								
Ankle Plantarflexion (S1-S2)								

Upper Extremity: [ ] WNL [ ] Weak [ ] other:_____
Upper Abdominals: [ ] WNL [ ] Weak [ ] other:_____
Lower Abdominals: [ ] WNL [ ] Weak [ ] other:_____

Reflexes:	Left				Right				Sensation:	Left		Right	
	0	+1	+2	+3	0	+1	+2	+3		Intact	Deficit	Intact	Deficit
Patellar (L3-L4)									L2-				
Achilles (S1-S2)									L3-				
									L4-				
Babinski's Sign	[ ] Positive [ ] Negative								L5-				
									S1-				
Special Tests:									S2-				



/// stabbing 000 pins & needles xxx burning
= = = numbness +++ aching

Pain Description:
Location:_____
_____
Severity: 0 to 10 scale
Now-_____Best-_____Worst-_____
Elicited by:_____
Relieved by:_____
Aggravated by:_____
Endurance:_____
Nature:
[ ] cramping [ ] aching [ ] shooting
[ ] burning [ ] throbbing [ ] tingling
[ ] stabbing [ ] sore [ ] numbness
[ ] pins/needles [ ] constant [ ] intermittent
[ ] duration:_____
[ ] radiates:_____

Palpation: *(PA glides, lateral & anterior glides, bony landmarks, soft tissue, apprehension, guarding, spasm)*_____
_____
_____

Assessment: _____
_____
_____
_____
_____
_____
_____

Recommendations:_____
_____
_____
_____
_____

Goals: [ ] Independent Understanding of Proper Movement Patterns & Body Mechanics
[ ] Independent Exercise Program
[ ] Decrease Pain Level from _____to _____ to permit_____
[ ] Normalize Postural Alignment
[ ] Other _____

Treatment Plan: [ ] Movement Patterns & Body Mechanics Instructions [ ] Moist Heat [ ] Massage
[ ] Mechanical Traction [ ] Manual Traction [ ] Mobilization [ ] Myofascial Release
[ ] Electrical Stimulation [ ] Ultrasound [ ] TENS [ ] Patient Education
[ ] Physical Medicine Consult [ ] Therapeutic Exercise Program:_____
[ ] Other:_____

Frequency of Treatment: _____Location of Treatment:_____

Assessment and Treatment Plan Discussed with the Patient [ ] Yes [ ] No (Reason) _____

_____ _____
Printed Name and Title of Physical Therapist/ Physical Therapist Signature Date of Evaluation