LUMBAR EVALUATION FORM

Date:
Pt name: Pt number:
Diagnosis:
Referred by:
Visit #:
Time In: Time Out: Billable Units:

Patient Information:

Patient Profile:

Chief Complaint:

Account of Current Condition:
- History of present injury:
- Current Symptoms:
  - ***L**ocation*:
  - ***O**nset*:
  - ***C**haracter*:
  - ***I**ntensity*:
  - ***D**uration*:
  - ***A**ggravating Factors*:
  - ***A**lleviating Factors*:
  - *24-hour behavior*:

PMH:
- Medication/Allergies:

Current Function %:
- Standardized Functional Questionnaire:
  - ☐ Modified Oswestry:
  - ☐ LEFS:

Personal and Environmental Factors:
- Activity:
- Occupation:

Patient Goals:

Systems Review:

Cardiopulmonary:
Neuromuscular:
Integumentary:
Musculoskeletal:

Tests and Measures:

Observation:
- Joint Clearing:

ROM:

	AROM		PROM		END FEEL	
Flexion						
Extension						
	L	R	L	R	L	R
Side Bend						
Rotation						

Resisted Tests:

Flexibility:

Neurologic Screen:

	Sensation		Reflexes		Motor	
	L	R	L	R	L	R
L1-L2						
L3						
L4						
L5						
S1						
S2						

Special Tests:

- ☐ *Slump Test:*
- ☐ *Straight Leg Raise Test:*
- ☐ *Cram Test:*
- ☐ *Sign of the Buttock Test:*
- ☐ *Prone Knee Bending Test:*
- ☐ *Valsalva's Maneuver Test:*
- ☐ *Segmental Instability Test:*
- ☐ *Anterior Lumbar Instability Test:*
- ☐ *One-legged Standing Lumbar Extension Test:*
- ☐ *Quadrant Test:*
- ☐ *Hoover Test:*
- ☐ *Bicycle Test:*
- ☐ *Trendelenberg Test:*

Joint Mobility:
Palpation:
Functional Tests:
Today's Intervention:

Evaluation:

Summary:
Impairments:
Functional Limitations:
Response to Today's Intervention:

Plan of Care:

Outcomes:
STG:
LTG:
Prognosis:

Intervention Plan:

Informed Consent:

(☐Patient or ☐Guardian) has been informed of all evaluation findings and treatment plans and agrees to participate in Physical Therapy services and plans as outline, including the given HEP.

Sign: _____
_____
_____

Date: