

Physician Name _____ O-() _____ F-() _____

1. Patient Name: _____ SS#: _____

2. Present Chief Complaints: C T L L-S
 Other: _____

3. Spine Pain Radiation:
 Level I: Pain localized to spin
 Level II: Pain radiating to the elbow or knee
 Level III: Pain radiating below the elbow or knee

4. Numeric Pain Rating Scale (NPRS):
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

5. Restrictions of Activities of Daily Living / Functional Index:
(no limitations) 0 1 2 3 4 5 6 7 8 9 10 (totally disabled)

6. Work Capabilities: Employed Unemployed No work limitations
 Capable of restricted work duties Unable to work

7. To date how does the patient describe their overall improvement since the initial visit on a scale of 0 to 100:
(none) 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% (total)

If there has been a CHANGE in the original diagnosis, please list below:

ICD9#: _____ Describe: _____
Associated with: ICD9#: _____ Describe: _____
Complicated by: ICD-9#: _____ Describe: _____
Secondary Dx: _____

8. Does the patient demonstrate any physical impairment related to this diagnosis and/or episode of care?
 Yes No

If yes, please provide the area of impairment, the degree of impairment and the reference source used to rate this impairment.

The Physician acknowledges that this Discharge Report has been personally reviewed, contains information, which is truthful and accurate, and has been submitted by authorized staff on behalf of Physician.

Physician's Signature

_____/_____/_____
Date