

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