CLAIMANT:
CASE NUMBER:

MUSCULOSKELETAL

1. Please include treatment notes, including X-ray reports
   From _____ To _____

2. Date first seen _____ Date last seen _____ Frequency of visits _____

3. Height _____ Weight _____ Date _____

4. Diagnosis _____ Onset of symptoms_____

5. Indicate **in degrees** the range of motion of involved joints. If abnormal, note any instability of joints.

Specify Joint of Involved Extremity	Flexion	Extension	Abduction	Adduction

6. Is there swelling? _____ Warmth? _____ Redness? _____ Tenderness? _____
   If so, which joints? _____ How often? _____

7. Are there paravertebral muscle spasms? _____ Tenderness? _____

8. Please describe any neurological abnormalities:
   Sensation_____
   Reflex_____
   Motor_____
   Straight Leg Raise: Sitting: ☐ + ☐ - Supine: ☐ + ☐ -

   Please use these ratings to describe your patient: 5/5

   0/5 no muscular contraction detected
   1/5 barely detectable trace of contraction
   2/5 active movement of the body part with gravity eliminated
   3/5 active movement against gravity
   4/5 active movement against gravity and some resistance
   5/5 active movement against full resistance without fatigue (normal strength)

9. Is atrophy present? ☐ Yes ☐ No
   If yes, please describe and provide measurements._____
   _____
   _____
   _____
   _____

10. Is there disorganization of motor function? If so, please describe gross and dexterous movements, gait and station. Yes _____

11. Please describe any limitations in reaching, handling or fingering. _____

Which hand or arm is affected? ☐ Left ☐ Right

12. Is there a fracture of a lower extremity? ☐ Yes ☐ No
If yes, date of fracture: _____
Date return to full weight-bearing occurred or is expected. _____
Is there evidence of non-union on X-ray? ☐ Yes ☐ No

13. Are there fractures, ankylosis, subluxations or joint deformities present? If so, please describe: Yes _____

14. If performed, please provide the results and dates of the following laboratory tests, or attach copies of the lab reports:
Rheumatoid Factor: Yes Date: _____ ANA Titer: Yes Date: _____

Sedimentation Rate: Yes Date: _____ Other: _____ Date: _____

15. Is an assistive device necessary for ☐ Standing? ☐ Walking?
Type of assistive device: _____
Medical basis for use of assistive device? _____
Impairment affects ☐ Left ☐ Right ☐ Both lower extremities.
Circumstances when device is required: _____

Do upper extremity limitations affect ability to lift/carry w/free hand?
☐ Yes ☐ No
If yes, describe: _____

16. Please describe your patient's response to treatment. _____

17. Prognosis:

_____
_____
_____
_____

18. What is the anticipated duration of symptoms?_____
_____
_____
_____

Thank you for your cooperation.

_____ _____
Signature of Physician Print or Type Name

_____
Date

(____) _____
Phone Best time to call