

WYOMING WORKERS' COMPENSATION DIVISION
 HEALTH CARE PROVIDER SPINE INJURY EVALUATION/RE-EVALUATION REPORT
Fax to 307-322-4763 or call 307-322-0291 for more information

PLEASE PRINT

First Name:	Middle Initial	Last Name	Claim Number

Date of Birth	Date of Injury	Last Day Worked

SUBJECTIVE

Explain the mechanism of injury:

Is this a Traumatic Injury? Yes No

Any prior injury to this part of body?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Location	<input type="checkbox"/> Lumbar <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic	Spinal Level:	
Quality of Symptoms:	<input type="checkbox"/> Intermittent <input type="checkbox"/> Constant	VAS (0:10 scale):	
When are symptoms worse	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night		
Headache present:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Lower Extremity	<input type="checkbox"/> Weakness <input type="checkbox"/> Paresthesia <input type="checkbox"/> Pain		
Upper Extremity	<input type="checkbox"/> Weakness <input type="checkbox"/> Paresthesia <input type="checkbox"/> Pain		
Saddle Numbness:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Loss of Coordination:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Bladder Dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No		

OBJECTIVE

Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type/Location:
Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol Use (amount)	Daily Weekly Monthly Occasionally	How long:
Tobacco Use:	Packs per day:	How long:
Illicit Drug Use:	<input type="checkbox"/> Yes <input type="checkbox"/> No	List:
Substance Abuse:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rehab, When:

ASSESSMENT

T	P	R	B/P	W	H	BMI
---	---	---	-----	---	---	-----

Current Medications:

Inspection:

Palpation:



Are there any strength deficits? Yes No

Are there any reflex deficits? Yes No

Are there any range of motion deficits? Yes No

Are there any neurological symptoms? Yes No

Are there any musculoskeletal symptoms? Yes No

What is the initial OSWESTRY score? _____

PLAN

Medications/Lab/Imaging:

Specific Modification/Restrictions:

Current Restrictions	<input type="checkbox"/> No Work	<input type="checkbox"/> Light-Modified Duty	<input type="checkbox"/> Full Duty
Dates:	Beginning:	Ending/Next Evaluation:	

Follow-up:

Name of Health Care Provider:	Phone Number
Address:	

Health Care Provider Signature

Date

Tax ID number

Clinic Name

