Spine Evaluation

Name:_____Sport:_____ Date:_____
BP:_____ HR:_____Practice_____Game_____ Evaluator:_____

HISTORY

a. Location of the pain_____
_____
_
b. Onset of the pain_____ _____
c. How the spine was injured_____
d. Consistency of the pain_____
e. Activities or positions that alter the level of symptoms_____
_____
f. Bowel or bladder signs_____
g. Prior history of spinal injury_____

OBSERVATION

General Inspection:
a. Sagittal curvature-description:_____
b. Test for Scoliosis-description:_____ _____
c. Frontal Curvature-description:_____
d. Observance of gait-description:_____
Cervical Spine:
a. Positon of the head on the shoulders:_____
b. Bilateral soft tissue parison:_____
c. Level of the shoulders:_____
Thoracic Spine:
a. Breathing patterns:_____
b. Bilateral comparisons of skinfolds: _____
Lumbar Spine:
a. General movement and posture:_____
b. Lordotic curve:_____
c. Standing posture:_____

PALPATION

RULE OUT A FRACTURE
(POSITIVE - NEGATIVE) COMPRESSION_____ PERCUSSION_____ DISTRACTION_____

	Tender	Crepitis		Tender	Crepitis
CERVICAL SPINE:			**Thoracic spinal bodies**:		
1. Hyoid bone	Yes - No	Yes - No	**6.** T1 vertebra	Yes - No	Yes - No
2. Thyroid cartilage	Yes - No	Yes - No	**7.** T3 vertebra	Yes - No	Yes - No
3. Cricoid cartilage	Yes - No	Yes - No	**8.** T7 vertebra	Yes - No	Yes - No
3.Cricoid cartilage	Yes - No	Yes - No	**LUMBAR SPINE:**		
4. Sternocleidomastoid	Yes - No	Yes - No	**1.** Paravertebrals	Yes - No	Yes - No
5. Carotid artery	Yes - No	Yes - No	**2.** Spinous processes	Yes - No	Yes - No
6. Lymph nodes	Yes - No	Yes - No	**3.** Step-off deformity	Yes - No	Yes - No
7. Occiput	Yes - No	Yes - No	**4.** Soft tissue palpation	Yes - No	Yes - No
8. Spinous processes	Yes - No	Yes - No	**Lumbar spinal bodies:**		
9. Transverse processes	Yes - No	Yes - No	**5.** L4 vertebra	Yes - No	Yes - No
10. Trapezius	Yes - No	Yes - No	**6.** L5 vertebrae	Yes - No	Yes - No
Cervical vertebral bodies:			**7.** S2	Yes - No	Yes - No
11. C2 transverse process	Yes - No	Yes - No	**SACRUM AND PELVIS**:		
12. C3 vertebra	Yes - No	Yes - No	**1.** Posterior Superior iliac spine	Yes - No	Yes - No
13. C4-C5 vertebrae	Yes - No	Yes - No	**2**. Iliac Crest	Yes - No	Yes - No
14. C6 vertebra	Yes - No	Yes - No	**3**. Pubic symphisis	Yes - No	Yes - No
THORACIC SPINE:			**4**. Greater trochanter	Yes - No	Yes - No
1. Bony palpation	Yes - No	Yes - No	**5.** Ischial tuberosity	Yes - No	Yes - No
2. Spinous processes	Yes - No	Yes - No	**6.** Gluteals	Yes - No	Yes - No
3. Costovertebral junction	Yes - No	Yes - No	**7.** Sciatic nerve	Yes - No	Yes - No
4. Soft tissue palpation	Yes - No	Yes - No			
5. Trapezius	Yes - No	Yes - No			

ASSESSING MOTION

	General ROM	Goniometer	End Feel	Muscle Testing w/Gravit	Muscle Testing w/out Gravity
Neck:					
Flexion (0-45)	_____	_____	_____	_____	_____
Extension (0-45)	_____	_____	_____	_____	_____
Lateral flexion (0-45)	_____	_____	_____	_____	_____
Roatation (0-60)	_____	_____	_____	_____	_____
Trunk:					
Flexion (0-80)	_____	_____	_____	_____	_____
Extension (0-20-30)	_____	_____	_____	_____	_____
Lateral flexion (0-35)	_____	_____	_____	_____	_____
Roatation (0-45)	_____	_____	_____	_____	_____

RATINGS

General ROM (Painfull-Limited-Full)
Goniometer (Prcentage of Angle)
End Feel Normal (Bony - Soft Tissue Apposition - Soft Tissue Stretch - Capsular Stretch)
Abnormal (Hard - Soft- - Firm - Springy Block - Empty - Spasm)
Muscle Testing w/Gravity (5 4 4- 3+ 3 3- 2+)
Muscle Testing w/out Gravity (2 2- 1+ 1 0)

STRESS TEST
(+1 +2 +3)

Foraminal Compression Test	L____	R____	Foraminal Distraction Test	L____	R____
Vertebral Artery Test	L____	R____	Valsalva Maneuver	L____	R____
Swallowing Test	L____	R____	Distraction Test	L____	R____
Spurling Test	L____	R____	Shoulder Abduction Test	L____	R____

NEUROLOGICAL EXAM
(POSITIVE - NEGATIVE)

NERVE ROOT LEVEL	SENSORY TESTING	MOTOR TESTING	REFLEX TESTING
C5	_____	_____	_____
C6	_____	_____	_____
C7	_____	_____	_____
C8	_____	_____	
T1	_____		
L1	_____	_____	
L2	_____	_____	_____
L3	_____	_____	_____
L4	_____	_____	_____
L5	_____	_____	
S1	_____	_____	

CIRCULATORY EXAM
(POSITIVE - NEGATIVE)

Brachial Pulse_____ Radial Pulse_____

FUNCTIONAL TESTS

ACTIVITY SPECIFIC
1.
2.
3.
4.
5.

NOTES

Impression:
_____
_____
_____

Referral: Emergency Room

Physician'sOffice:

Acute Management: Crutches____ Posterior Splint____ Compression Bandage____ Air Cast ____ Vacuum Splint____ Speedi Splint____

Diagnostic Tests:

X-rays: Anterior/Posterior view
Lateral view
Mortis view
Anterior/Posterior view with stress

BoneScan: