

DEPARTMENT OF THE ARMY  
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND  
2050 Worth Road  
Fort Sam Houston, Texas 78234-6000

MEDCOM Circular  
No. 40-6

24 January 2005

Expires 24 January 2007  
Medical Services

**LOW BACK PAIN DOCUMENTATION FORM**

**1. HISTORY.** This issue publishes a revision of this publication. Because the publication has been extensively revised, the changed portions have not been highlighted.

**2. PURPOSE.**

a. This circular provides policy and implementing instructions for beta testing U.S. Army Medical Command (MEDCOM) Form 695-R (Low Back Pain).

b. This form will facilitate, and thus improve, the documentation of practitioners in their care of patients seeking treatment for symptoms of low back pain by cueing the practitioner to document key aspects in the assessment and treatment of low back pain. These key aspects were identified by a thorough examination of the scientific evidence on low back pain by a panel of expert consultants from the Army, Navy, Air Force, and Veterans Administration (VA). The evidence on treatment of low back pain was synthesized by these experts in the Department of Defense (DOD)/VA Practice Guideline on the Treatment of Low Back Pain. These key aspects were then transformed into the low back pain documentation form.

**3. APPLICABILITY.** This circular applies to any practitioner using the form in the care of patients seeking treatment for low back pain in lieu of the standard form (SF) 600 (Health Record—Chronological Record of Medical Care).

**4. REFERENCES.** AR 40-66, Medical Record Administration and Health Care Documentation, provides guidance on medical record documentation and is applicable.

---

\*This circular supersedes MEDCOM Circular 40-6, 24 January 2003.

**5. EXPLANATION OF ABBREVIATIONS AND TERMS.**

a. Abbreviations.

DOD.....Department of Defense  
MEDCOM.....U.S. Army Medical Command  
MTF.....military treatment facility  
OTR.....outpatient treatment record  
SF.....standard form  
VA.....Veterans Administration

b. Terms. See AR 40-66.

**6. RESPONSIBILITIES.** See AR 40-66.

**7. POLICY.**

a. Military treatment facilities (MTFs) may use the low back pain documentation form prescribed herein for the period of the test, through 24 January 2007, or as directed by MEDCOM.

b. The MEDCOM test form addressed in this circular will be filed in the outpatient treatment record (OTR), with the SF 600, in chronological order.

c. The OTR form prescribed herein replaces the SF 600 only in patients being treated on an outpatient basis for treatment of low back pain.

d. All current requirements of AR 40-66, other than those addressed in this circular, remain in effect.

**8. INSTRUCTIONS FOR USE OF THE LOW BACK PAIN DOCUMENTATION FORM.**

Note: The form authorized for local reproduction (that is, "-R" form) is contained in appendix A of this circular.

a. Purpose. MEDCOM Form 695-R may be used by any provider to document the treatment of patients with complaints of low back pain.

b. Preparation. This form has three sections: a vital signs section, a patient section, and a practitioner section. Section I, the vital signs section, is to be completed by ancillary staff. Section II, the patient section, is to be completed by the patient. Section III is to be completed by the provider.

c. Content. Section I, to be completed by ancillary staff, includes documentation of height, weight, vital signs, and an assessment of the duration of the low back pain. Section II, the patient section--to be completed by the patient--includes demographic, injury, symptom, work history, job characteristic, and pre-injury stress factor questions.

Section III, the provider section, includes check box and free-hand areas for documentation of the patient's medical history, physical assessment, diagnosis, and treatment plan.

**Appendix A**

Appendix A contains the following "-R" form (authorized for local reproduction).

MEDCOM Form 695-R (Low Back Pain)

<input type="checkbox"/> Initial visit <input type="checkbox"/> Follow up visit	<b>MEDICAL RECORD - LOW BACK PAIN</b> For use of this form see MEDCOM Cir 40-6	DATE
<b>SECTION I - VITAL SIGNS (To be completed by Ancillary Support Staff)</b>		
Time: _____ Temp: _____ Pulse: _____ Resp: _____ BP: _____ Ht: _____ Wt: _____ Age: _____ Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No    Want to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No    Cessation material provided? <input type="checkbox"/> Yes <input type="checkbox"/> No Allergy: _____    Duration of present episode of back pain: <input type="checkbox"/> < 6 weeks <input type="checkbox"/> > 6 weeks		
<b>SECTION II - DEMOGRAPHICS (To be completed by Patient/Reviewed by Provider)</b>		
<b>PART A - MEDICATIONS (List your current medications and dose)</b>		
<b>PART B - INJURY / SYMPTOMS</b>		
1. Please rate the severity of your back pain during the past week by marking the pain scale below. No pain      0      1      2      3      4      5      6      7      8      9      10      Worst pain you've ever had		
2. During the past week did you experience any pain, numbness or tingling in either of your legs? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. In the past, have you experienced any of the following? Back pain? <input type="checkbox"/> Yes <input type="checkbox"/> No      Back surgery, or was back surgery recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No Back rehabilitation? <input type="checkbox"/> Yes <input type="checkbox"/> No      Pain, numbness or tingling in either of your legs? <input type="checkbox"/> Yes <input type="checkbox"/> No		
4. Please rate your current stress level by marking the stress scale below. No stress      0      1      2      3      4      5      6      7      8      9      10      High Stress		
<b>PART C - WORK HISTORY / JOB CHARACTERISTICS</b>		
1. What is your current job title (civilian) or MOS (military) and work site: _____ 2. Does your job require (check all that apply): _____ <input type="checkbox"/> Lifting? How often? _____ /hour <input type="checkbox"/> Twisting your back while lifting or lowering? <input type="checkbox"/> Lifting objects overhead? How often? _____ /hour <input type="checkbox"/> Use of vibrating equipment or tools? <input type="checkbox"/> Pushing/Pulling? How often? _____ /hour <input type="checkbox"/> Sitting for long periods without getting up?		
<b>SECTION III - MEDICAL HISTORY, ASSESSMENT, DIAGNOSIS, AND TREATMENT (To be completed by Provider)</b>		
Patient's chief complaint: _____		
<b>PART A - HISTORY OF PRESENT ILLNESS</b>		
1. Cause of back pain: <input type="checkbox"/> Non-Traumatic <input type="checkbox"/> Traumatic (Describe below): _____ _____ _____		
2. If non-traumatic, does the patient have any of the following red flag risk factors? Age > 50    - - - - - <input type="checkbox"/> Yes <input type="checkbox"/> No                      History of cancer    - - - - - <input type="checkbox"/> Yes <input type="checkbox"/> No Fevers        - - - - - <input type="checkbox"/> Yes <input type="checkbox"/> No                      Metabolic disorder    - - - - - <input type="checkbox"/> Yes <input type="checkbox"/> No Night pain    - - - - - <input type="checkbox"/> Yes <input type="checkbox"/> No                      Bowel or bladder symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No Unexplained weight loss    - - <input type="checkbox"/> Yes <input type="checkbox"/> No                      Saddle anesthesia    - - - - - <input type="checkbox"/> Yes <input type="checkbox"/> No Comments: _____		
PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)		_____ (Patient's Signature)

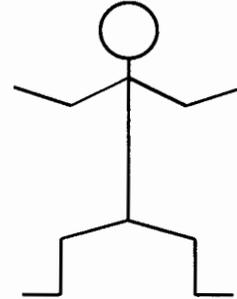
**PART B - PAST MEDICAL HISTORY**

- Duodenal ulcer
- Pancreatitis
- Irritable bowel syndrome
- Diverticulitis
- Abdominal aortic aneurysm
- Pyelonephritis
- Prostatism
- Ovarian disease
- PID
- Vascular claudication

Comments: \_\_\_\_\_

**PART C - PHYSICAL ASSESSMENT**

- |                                  |                                 |                                   |
|----------------------------------|---------------------------------|-----------------------------------|
| Posture - - - - -                | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Gait - - - - -                   | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Straight leg raise - - - - -     | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Reflexes (knee, ankle, babinski) | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Sensation (L4-5 / S1) - - - -    | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Strength (L4-5 / S1) - - - - -   | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| ROM (flex/ext/RSB/LSB/ro) - -    | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Wadells sign - - - - -           | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Tender to palpation: - - - - -   | <input type="checkbox"/> No     | <input type="checkbox"/> Yes      |



Comments or description of abnormalities: \_\_\_\_\_

**PART D - DIAGNOSIS**

- Acute low back pain
- Chronic low back pain
- Acute sciatica
- Chronic sciatica / limb pain
- Other (Specify): \_\_\_\_\_

**PART E - TREATMENT PLAN**

1. **MEDICATION:**  Acetaminophen 500 mg 1-2 po every 4 hr  ASA 325 mg 1-2 po every 4 hr  
 Ibuprofen 600/800 mg po every 8 hr  Other (Specify): \_\_\_\_\_
2. **IMAGING (Indicate type and reason):**  X-ray  MRI or  CT Myelogram  Other: \_\_\_\_\_  
 > 50 or < 18 years of age  No improvement in 4-6 weeks  
 Pain at rest or night pain  R/O ankylosing spondylitis/spondylo-arthropathy  
 No history of CA  Low energy trauma in high risk patient (osteoporosis)  
 Fever > 38C or 100.4F > 48 hours  High energy trauma (fall from height, MVA)  
 Neuromotor deficit  History of drug/alcohol abuse  
 Other (Specify): \_\_\_\_\_
3. **LAB:** \_\_\_\_\_
4. **REFERRAL:**

<input type="checkbox"/> Self-care	<input type="checkbox"/> Advised to stop using tobacco
<input type="checkbox"/> Self-care patient materials provided	<input type="checkbox"/> Referral to tobacco cessation program
<input type="checkbox"/> Advised to reduce weight	<input type="checkbox"/> Referral to back class/school
<input type="checkbox"/> Referral to dietician for weight reduction	<input type="checkbox"/> Referral to physical therapy
<input type="checkbox"/> Advised about stress management	<input type="checkbox"/> Referral to neuro surgeon
<input type="checkbox"/> Referral to stress management	<input type="checkbox"/> Referral to orthopedic surgeon
<input type="checkbox"/> Other (Specify): _____	
5. **DUTY STATUS:**  Full activity  Modified duty  Quarters \_\_\_\_\_  Comment: \_\_\_\_\_  
 Profile \_\_\_\_\_
6. **FOLLOW-UP:**  None  48 hours  1-3 weeks  6 weeks  
 Patient instructed to contact clinic ASAP if symptoms worsen.

(Provider's Name)

(Provider's Signature)

**The proponent of this publication is the Office of the Assistant Chief of Staff for Health Policy and Services. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, U.S. Army Medical Command, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6026.**

FOR THE COMMANDER:



JOSEPH G. WEBB, JR.  
Major General, DC  
Chief of Staff

CHARLES C. HUME  
Colonel, MS  
Assistant Chief of Staff for  
Information Management

**DISTRIBUTION:**

This publication is available in electronic media only and is intended for MEDCOM distribution Ca and Da.

**SPECIAL DISTRIBUTION:**

MCHC (Stockroom) (1 cy)  
MCHS-AS (Forms Mgr) (1 cy)  
MCHS-AS (Editor) (2 cy)