

AMA Guides Sixth Edition Musculoskeletal Impairment Evaluation Report Form

Examinee: _____

Identification Number: _____ Date of Birth: _____

Date of Examination: _____

Examining Physician: _____

Date of Injury: _____

Referral Source: _____

Employer: _____

Occupation: _____

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INTRODUCTION

- This identity of the examinee was confirmed.
- The examination process was explained to the examinee, and the examinee understands that no patient / treating physician relationship was established.
- The examinee was advised that the information provided will not be confidential and a report will be sent to the requesting client. Informed consent was obtained with the examinee providing written permission to proceed with the evaluation, including the physical examination.
- The individual was advised not to do anything during the examination that would result in harm and agreed to notify us immediately of any difficulties during the examination.
- The examinee was advised of the evaluation process, provided consent to proceed, and then completed a questionnaire and a series of pain inventories.
- The examinee reported no difficulties occurring during the examination.
- Chaperone / assistant was present during the examination

Times: Evaluation Start: _____ Evaluation Completion: _____ Total Time: _____

Individuals Accompanying: None _____
 Waited Observed

Cooperation: Cooperative Non-Cooperative

History (per Examinee): Good Fair Poor
 Consistent with Records Inconsistent with Records
 Questionnaire and Functional Inventories Completed

MEDICAL RECORD REVIEW

- Medical records provided were reviewed.
- Medical record summary prepared.

HISTORY

- Questionnaire completed.
- History dictated.

PHYSICAL EXAMINATION

Observations

Height: _____ Feet _____ Inches **Weight:** _____ pounds Reported Measured

Assistant devices: None _____

Callus: None Mild Moderate Marked

Affect: Normal Flat Excitable

Appearance: Comfortable Uncomfortable

Pain Behaviors: None Mild Moderate Marked

Non-Physiologic Findings: None Mild Moderate Marked

All range of motion measurements in this case were performed as instructed in the *AMA Guides to the Evaluation of Permanent Impairment*, Sixth Edition. Warm-up movements were performed and measurements were reproducible within 10%, unless otherwise noted.

* Indicates Physical Examination Adjustment Factor

Instructions: Complete assessment for regions involved in the assessment; record findings bilaterally

Regions Examined:

- Spine
 - Cervical
 - Thoracic
 - Lumbar

- Neurological
 - Upper Extremity
 - Lower Extremity

- Upper Extremity
 - Shoulder
 - Elbow
 - Wrist
 - Hand

- Lower Extremity
 - Hip
 - Knee
 - Foot / Ankle

Cervical Examination

Inspection

Curves: Normal Abnormal: _____

Posture: Normal Abnormal: _____

Scars: Normal Abnormal: _____

Palpation

Tenderness None Abnormal: _____

Muscle spasm None Abnormal: _____

Muscle guarding None Abnormal: _____

Cervical Compression* Negative Positive: _____

Reproducible radicular pain

Cervical Range of Motion

Range of motion measurements were performed using an inclinometer. Consistent? No Yes

Motion	# 1	#2	# 3	Maximum
Flexion (Forward)				
Extension (Backward)				
Right Lateral				
Left Lateral				
Right Rotation				
Left Rotation				

Thoracic Examination

Inspection

Curves: Normal Abnormal: _____

Posture: Normal Abnormal: _____

Scars: Normal Abnormal: _____

Thoracic Palpation

- Tenderness None Abnormal: _____
- Muscle spasm None Abnormal: _____
- Muscle guarding None Abnormal: _____

Lumbar Examination

Inspection

- Curves: Normal Abnormal: _____
- Posture: Normal Abnormal: _____
- Scars: Normal Abnormal: _____

Palpation

- Tenderness None Abnormal: _____
- Muscle spasm None Abnormal: _____
- Muscle guarding None Abnormal: _____

Lumbar Range of Motion

Range of motion measurements were performed using an inclinometer. Consistent? No Yes

Motion	# 1	#2	# 3	Maximum
Flexion (Forward)				
Extension (Backward)				
Right Lateral				
Left Lateral				

Neurological Examination of Upper Extremity

Upper Extremity Deep Tendon Reflexes*

Normal Abnormal: _____

Reflex	Level	Right	Left
Biceps	C-5		
Triceps	C-7		
Brachioradialis	C-5-7		

Upper Extremity Motor Examination*

Reference Table 15-14, 6th ed, 425)

Normal Abnormal: _____
 Consistent? No Yes

		Right	Left	Atrophy
Upper arm circumference*	10 cm. above the elbow	cm.	cm.	cm.
Forearm circumference*	10 cm. below the elbow	cm.	cm.	cm.

Upper Extremity Sensory Examination*

(Reference Table 15-14, 6th ed, 425)

Normal Abnormal: _____
 Consistent? No Yes

Diminished light touch Decreased protective sensibility Absent sensibility

Neurological Examination of Lower Extremity

Lower Extremity Deep Tendon Reflexes*

Normal Abnormal: _____

Reflex	Level	Right	Left
Knee	L-4		
Ankle	S-1		

Lower Extremity Motor Examination*

(Reference Table 16-11, 6th ed, 533)

Normal Abnormal: _____
 Consistent? No Yes

		Right	Left	Atrophy
Thigh	10 cm. above the patella	cm.	cm.	
Calf	Mid calf	cm.	cm.	

Lower Extremity Sensory Examination*

(Reference Table 16-11, 6th ed, 533)

Normal Abnormal: _____
 Consistent? No Yes

Diminished light touch Decreased protective sensibility Absent sensibility

Straight Leg Raising

Negative Abnormal: Positive with reproducible radicular pain at 35° -70 °

	Right Angle	Right Response	Left Angle	Left Response
Sitting				
Supine				

Non-Organic Findings

Negative Positive: _____

Upper Extremity Examination

Inspection

Scars: Negative Positive: _____

Deformity: Negative Positive: _____

Discoloration: Negative Positive: _____

Atrophy: Negative Positive: _____

Swelling: Negative Positive: _____

Palpation

Tenderness: Negative Positive: _____

Shoulders

Inspection* Normal Abnormal: _____

Impingement Signs Normal Abnormal: _____

Stability* Normal Abnormal: _____

Alignment/Deformity* Normal Abnormal: _____

Palpation* Normal Abnormal: _____

Right Shoulder Motion

(Reference Table 15-34, 6th ed, 475)

Motion	Normal	# 1	# 2	# 3	Consistent?
Flexion	180 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Extension	50 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Adduction	40 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Abduction	170 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Internal Rotation	80 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
External Rotation	60 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Total					

Left Shoulder Motion

(Reference Table 15-34, 6th ed, 475)

Motion	Normal	# 1	# 2	# 3	Consistent?
Flexion	180 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Extension	50 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Adduction	40 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Abduction	170 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Internal Rotation	80 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
External Rotation	60 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Total					

Elbows

Inspection* Normal Abnormal: _____

Stability* Normal Abnormal: _____

Alignment/Deformity* Normal Abnormal: _____

Palpation* Normal Abnormal: _____

Right Elbow Motion

(Reference Table 15-33, 6th ed, 474)

Motion	Normal	# 1	# 2	# 3	Consistent?
Flexion	140 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Extension	0 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Supination	70 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Pronation	80 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Total					

Left Elbow Motion

(Reference Table 15-33, 6th ed, 474)

Motion	Normal	# 1	# 2	# 3	Consistent?
Flexion	140 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Extension	0 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Supination	70 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Pronation	80 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Total					

Wrists

Inspection* Normal Abnormal: _____

Stability* Normal Abnormal: _____

Alignment/Deformity* Normal Abnormal: _____

Palpation* Normal Abnormal: _____

Right Wrist Motion

(Reference Table 15-32, 6th ed, 473)

Motion	Normal	# 1	# 2	# 3	Consistent?
Flexion	60 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Extension	60 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Radial Deviation	20 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Ulnar Deviation	30 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Total					

Left Wrist Motion

(Reference Table 15-32, 6th ed, 473)

Motion	Normal	# 1	# 2	# 3	Consistent?
Flexion	60 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Extension	60 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Radial Deviation	20 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Ulnar Deviation	30 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Total					

Hands

Inspection* Normal Abnormal: _____

Stability* Normal Abnormal: _____

Alignment/Deformity* Normal Abnormal: _____

Palpation* Normal Abnormal: _____

Motion* Normal Abnormal: _____

Lower Extremity Examination

Inspection

Gait: Normal Abnormal: _____

Scars: Negative Positive: _____

Deformity: Negative Positive: _____

Discoloration: Negative Positive: _____

Atrophy: Negative Positive: _____

Swelling: Negative Positive: _____

Palpation

Tenderness: Negative Positive: _____

Hips

Inspection* Normal Abnormal: _____

Stability* Normal Abnormal: _____

Alignment/Deformity* Normal Abnormal: _____

Palpation* Normal Abnormal: _____

Right Hip Motion

(Reference Table 16-24, 6th ed, 549)

Motion	Normal	# 1	# 2	# 3	Consistent?
Flexion	> 100 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Extension	< 10 ° flexion contracture				<input type="checkbox"/> Yes <input type="checkbox"/> No
Internal Rotation	> 20 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
External Rotation	> 30 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Abduction	> 25 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Adduction	> 15 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Total					

Left Hip Motion

(Reference Table 16-24, 6th ed, 549)

Motion	Normal	# 1	# 2	# 3	Consistent?
Flexion	> 100 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Extension	< 10 ° flexion contracture				<input type="checkbox"/> Yes <input type="checkbox"/> No
Internal Rotation	> 20 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
External Rotation	> 30 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Abduction	> 25 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Adduction	> 15 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Total					

Knees

Inspection* Normal Abnormal: _____

Stability* Normal Abnormal: _____

Alignment/Deformity* Normal Abnormal: _____

Palpation* Normal Abnormal: _____

Right Knee Motion

(Reference Table 16-23, 6th ed, 549)

Motion	Normal	# 1	# 2	# 3	Consistent?
Flexion	> 109 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Flexion Contracture	< 5 ° flexion contracture				<input type="checkbox"/> Yes <input type="checkbox"/> No
Total					

Left Knee Motion

(Reference Table 16-23, 6th ed, 549)

Motion	Normal	# 1	# 2	# 3	Consistent?
Flexion	> 109 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Flexion Contracture	< 5 ° flexion contracture				<input type="checkbox"/> Yes <input type="checkbox"/> No
Total					

Foot / Ankle

Inspection* Normal Abnormal: _____
Stability* Normal Abnormal: _____
Alignment Deformity* Normal Abnormal: _____
Palpation* Normal Abnormal: _____

Right Ankle Motion

(Reference Table 16-22, 6th ed, 549)

Motion	Normal	# 1	# 2	# 3	Consistent?
Plantar flexion	> 20 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Extension (Dorsiflexion)	> 10 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Total					

Left Ankle Motion

(Reference Table 16-23, 6th ed, 549)

Motion	Normal	# 1	# 2	# 3	Consistent?
Plantar flexion	> 20 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Extension (Dorsiflexion)	> 10 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Total					

Right Hindfoot Motion

(Reference Table 16-22, 6th ed, 549)

Motion	Normal	# 1	# 2	# 3	Consistent?
Inversion	> 20 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Eversion	> 10 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Total					

Left Hindfoot Motion

(Reference Table 16-23, 6th ed, 549)

Motion	Normal	# 1	# 2	# 3	Consistent?
Inversion	> 20 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Eversion	> 10 °				<input type="checkbox"/> Yes <input type="checkbox"/> No
Total					

DIAGNOSTIC STUDIES

Study	Date	Findings	Severity of Findings				
			Normal	Mild	Moderate	Severe	Very Severe

FUNCTIONAL INVENTORIES

Pain Drawing

Completed and attached

Pain Disability Questionnaire – PDQ (Spine and Pain)

Completed and attached

QuickDASH (Upper Extremities)

Completed and attached

AAOS Lower Limb Outcome Scale (Lower Extremities)

Completed and attached

FUNCTIONAL GRADES

□ Circle as appropriate

Grade Modifier	Involvement	0	1	2	3	4
		Normal	Mild	Moderate	Severe	Very Severe
Upper Extremities	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> n/a	Asymptomatic	Pain / symptoms with strenuous / vigorous activity AND Able to perform self-care activities independently	Pain / symptoms with normal activity AND Able to perform self-care activities with modification but unassisted	Pain / symptoms with less than normal activity AND Requires assistance to perform self-care activities	Pain / symptoms a AND Unable to perform self-care activities at rest
QuickDASH Score		0-20	21-40	41-60	61-80	81-100
Lower Extremities	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> n/a	No Problem	Antalgic limp with asymmetric shortened stance, corrects with footwear modifications and/or orthotics	Antalgic limp (in the presence of objectively defined significant pathology) with asymmetric shortened stance stable with use of external orthotic device (e.g. ankle-foot orthosis), routine use single gait aid (cane or crutch), or positive Trendelenburg	Antalgic / unstable transfers and ambulation requires routine use of gait aids (2 canes or crutches) or KAFO brace	Non-ambulatory
Spine	<input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> n/a	Asymptomatic problem resolved; inconsistent symptoms	Pain; symptoms with strenuous / vigorous activity	Pain; symptoms with normal activity	Pain; symptoms with less-than-normal activity (minimal activity)	Pain; symptoms at rest, limited to sedentary activity
Pain Disability Index		0	1 – 70	71 – 100	101-130	131 - 150

CONCLUSIONS

Report dictated

Diagnoses (listed in order of severity)	Body Region (Right / Left) or Organ System	Functional Grade (0-4)	Causally Related?	Maximal Medical Improvement?
1			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ?
2			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ?
3			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ?
4			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ?
5			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ?
6			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ?

Comments:

Signed: _____

Date: _____

Written: _____