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)
<table>
<thead>
<tr>
<th>Time:</th>
<th>Temp:</th>
<th>Pulse:</th>
<th>Resp:</th>
<th>BP:</th>
<th>HT:</th>
<th>WT:</th>
<th>Age:</th>
</tr>
</thead>
</table>

Do you use tobacco? | Yes | No |
Want to quit? | Yes | No |
Cessation material provided? | Yes | No |

Allergy: 
Duration of present episode of back pain: | < 6 weeks | > 6 weeks |

**SECTION II - DEMOGRAPHICS (To be completed by Patient/Reviewed by Provider)**

**PART A - MEDICATIONS**
(List your current medications and doses)

**PART B - INJURY / SYMPTOMS**

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? | Yes | No |
3. In the past, have you experienced any of the following?
   - Back pain? | Yes | No |
   - Back surgery, or was back surgery recommended? | Yes | No |
   - Back rehabilitation? | Yes | No |
   - Pain, numbness or tingling in either of your legs? | Yes | 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 |
   |

**PART C - WORK HISTORY / JOB CHARACTERISTICS**

1. What is your current job title (civilian) or MOS (military) and work site?

2. Does your job require (check all that apply):  
   - Lifting? How often? _____hour  
   - Lifting objects overhead? How often? _____hour  
   - Twisting your back while lifting or lowering?  
   - Pushing/Falling? How often? _____hour  
   - Sitting for long periods without getting up?

**SECTION III - MEDICAL HISTORY, ASSESSMENT, DIAGNOSIS, AND TREATMENT (To be completed by Provider)**

Patient’s chief complaint:

**PART A - HISTORY OF PRESENT ILLNESS**

1. Cause of back pain: 
   - Non- Traumatic  
   - Traumatic  (Describe below):

2. If non-traumatic, does the patient have any of the following red flag risk factors?

   | Age > 50 | Yes | No |
   | Fevers | Yes | No |
   | Night pain | Yes | No |
   | Unexplained weight loss | Yes | No |
   - History of cancer  
   - Metabolic disorder  
   - Bowel or bladder symptoms  
   - Saddle anesthesia  

Comments:

**PATIENT’S IDENTIFICATION**  
Name - last, first, middle; grade, date; hospital or medical facility

(Patient’s Signature)
PART A - PAST MEDICAL HISTORY
- Duodenal ulcer
- Pancreatitis
- Irritable bowel syndrome
- Diverticulitis
- Abdominal aortic aneurysm
- Pyelonephritis
- Postasthm
- Ovarian disease
- PID
- Vascular claudication

Comments or description of abnormalities:

PART C - PHYSICAL ASSESSMENT
- Posture: Normal
- Gait: Normal
- Straight leg raise: Normal
- Reflexes (knee, ankle, Babinski): Normal
- Sensation (L4-5 / S1): Normal
- Strength (L4-5 / S1): Normal
- ROM (flex/ext/RSB/LSB/roll): Normal
- Wadles sign: Normal
- Tender to palpation: No

PART D - DIAGNOSIS
- Acute low back pain
- Chronic low back pain
- Acute sciatica
- Chronic sciatica / limb pain

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:

3. LAB:

4. REFERRAL:
- Self-care
- Self-care patient materials provided
- Referral to dietician for weight reduction
- Advised about stress management
- Referral to stress management
- Other (Specify):
- Advised to stop using tobacco
- Referral to tobacco cessation program
- Referral to physical therapy
- Referral to orthopedic surgeon

5. DUTY STATUS:
- Full activity
- Modified duty
- Quarters
- Comment:

6. FOLLOW-UP:
- None
- 48 hours
- 1-2 weeks
- 6 weeks
- Patient instructed to contact clinic ASAP if symptoms worsen.

MEDCOM FORM 695-R (TEST) / MCHD JUN 2000, Back
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.

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