MIBAC Clinical Form

Patient's Full Name:_____ Patient's DOB mm/dd/yyyy:_____

Complete this form regarding the patient's initial visit with you for the current episode of back-related symptoms or current new flare (new episode or flare within 6 months)

Date of **your** first visit with the patient for current back-related symptoms (new episode/flare within 6 months) mm/dd/yyyy: _____

Is this the patient's first visit (with any provider) for this episode of acute low back pain? ___ yes ___no
Was this visit: ___in-person ___virtual (synchronous only)

Race:

☐American Indian or Alaska Native
☐Asian
☐Black or African American
☐Multiracial
☐Native Hawaiian or other Pacific Islander
☐White
☐Unknown

Ethnicity:
☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

History of Present Illness

Duration of current back-related symptoms (the duration of symptoms or of the acute flare):

☐ Less than 1 week	☐ 1-4 weeks
☐ 1-2 months	☐ 3-6 months
☐ Greater than 6 months (Patient is not eligible, please review enrollment criteria)	

Cause of current back-related symptoms:

☐ Trauma or Injury	☐ Activity-related
☐ Other	☐ Unable to determine

Patient History/Status

History of low back pain prior to this episode?	☐ Yes	☐ No
Prior spine surgery related to the low back?	☐ Yes	☐ No
Current user of tobacco products?	☐ Yes	☐ No

Comorbidities - current or "history of" except as indicated (please select all that apply):

☐ Cancer (other than non-melanoma skin cancer)	☐ Compression Fracture
☐ Depression/Anxiety	☐ Diabetes - Type 2
☐ Immunosuppression (current)	☐ Injection Drug Use
☐ Joint Replacement (Total Hip or Knee)	☐ Obesity
☐ Osteoporosis	☐ Pregnancy (current)
☐ Rheumatologic/Connective Tissue Disease	☐ Scoliosis
☐ Stroke	☐ None of the above

Please list the most current weight and height values measured within the past 12 months **or** as reported by the patient: Weight (lbs)_____ Height (in)_____

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Has the patient been taking medications on a consistent basis (more than half the days) for the past 30 days?	☐ Yes*	☐ No

*If yes, please select the medications that the patient has been taking.

☐ Acetaminophen (Tylenol)	☐ Antidepressant - SNRI e.g., Duloxetine (Cymbalta), Venlafaxine (Effexor), etc.
☐ Antidepressant - SSRI e.g., Fluoxetine (Prozac), Sertraline (Zoloft), etc.	☐ Antidepressant Tricyclic, e.g., Nortriptyline (Pamelor), Amitriptyline (Elavil), etc.
☐ Benzodiazepines, e.g., Diazepam (Valium), Lorazepam (Ativan), Alprazolam (Xanax), etc.	☐ Gabapentinoids, e.g., Gabapentin (Neurontin), Pregabalin (Lyrica), etc.
☐ Muscle Relaxers (besides Benzodiazepines), e.g., Cyclobenzaprine (Flexeril), Methocarbamol (Robaxin), etc.	☐ NSAIDS, e.g., Ibuprofen, Naprosyn, etc.
☐ Opioids	☐ Steroids - Oral
☐ None of the above	☐ Unknown

Did you test lower extremity reflexes? ☐ Yes* ☐ No

*If yes, findings for lower extremity reflexes: ☐ Normal ☐ Decreased ☐ Increased

Did you perform Straight Leg Raise and/or Slump Test? ☐ Yes* ☐ No

*If tested, findings Straight Leg Raise/Slump Test: ☐ Negative ☐ Positive

Is there any evidence of the following, based on history or exam today?

- ☐ Aortic Dissection
- ☐ Cauda Equine Syndrome
- ☐ Foot Drop
- ☐ Infection which may be related to the low back
- ☐ Unexplained weight loss
- ☐ None of the above
- ☐ Not assessed

Treatment/Plan/Recommendations

Did you perform a Spinal Adjustment or Osteopathic/Spinal Manipulation Therapy at this visit?

☐ Yes ☐ No ☐ No, but I plan to within the next 2 months.

Did you recommend any of the following at this visit?

- ☐ Bracing
- ☐ Modified work activity (off work)
- ☐ Modified work activity (restrictions)
- ☐ Orthotics
- ☐ Specific exercise/stretching regimen
- ☐ Staying active, doing usual activities
- ☐ None of the above

Medications prescribed or recommended at this visit (MD/DO/APP)?

☐ Yes* (see page 3) ☐ No

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*If you recommended/prescribed medications, please select those medications below.

☐ Acetaminophen (Tylenol)	
☐ Antidepressant - SNRI e.g., Duloxetine (Cymbalta), Venlafaxine (Effexor), etc.	
☐ Antidepressant - SSRI e.g., Fluoxetine (Prozac), Sertraline (Zoloft), etc.	
☐ Antidepressant Tricyclic, e.g., Nortriptyline (Pamelor), Amitriptyline (Elavil), etc.	
☐ Benzodiazepines, e.g., Diazepam (Valium), Lorazepam (Ativan), Alprazolam (Xanax)	
☐ Gabapentinoids, e.g., Gabapentin (Neurontin), Pregabalin (Lyrica), etc.	
☐ Natural supplement	
☐ Muscle Relaxers (besides Benzodiazepines), e.g., Cyclobenzaprine (Flexeril), Methocarbamol (Robaxin), etc.	
☐ NSAIDS, e.g., Ibuprofen, Naprosyn, etc.	
☐ Opioids	☐ Steroids - Oral
☐ None of the above	☐ Unknown

Did you make any referrals and/or order tests at this visit? ☐ Yes* ☐ No

*If yes, select referrals made and/or tests ordered at this visit for current back-related symptoms

Please do not select your own discipline. Include tests performed within your own clinic.

☐ Acupuncture	☐ Behavioral Health
☐ Care/Case Manager	☐ Chiropractor (do not select if you are a DC)
☐ Dietician or Nutritionist	☐ Ergonomic Evaluation/Education Program
☐ Functional Medicine	☐ Neurology
☐ Osteopathic Manipulative Therapy/Osteopathic Manipulative Medicine	☐ Pain Clinic
☐ Physician Medicine and Rehabilitation (Physiatry)	☐ Physical Therapy
☐ Primary Care Physician (do not select if you are a PCP)	☐ Surgeon
☐ Therapeutic Massage	☐ Urgent Care/Emergency Room
☐ Weight Loss Program	☐ Test - CT Scan
☐ Test - EMG	☐ Test - MRI
☐ Test - X-ray	☐ Test - Other
☐ None of the above	☐ Other

End of clinical data elements. The patient and clinician information must be completed on the next page with the signature of the visit clinician.

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Patient Information and Demographics

- Please verify the following prior to submission:
- *All* fields are complete (so we may fully enroll the patient)
- The patient's email address is included if the patient does not consent to texts/sms
- The patient's name and DOB are on each of the 4 pages

MRN (Required):	Patient DOB (mm/dd/yyyy):
Patient's sex at birth (M/F):	
Patient's Email Address:	
Did the patient consent to texts (Y/N):	Patient's cell #: ( ) -

Office and Clinician Information

Clinician's Full Name:
Form completed by (if not the visit clinician):
Form faxed by:
Date form faxed:
Email address for follow-up questions:

I personally evaluated the patient today, and have reviewed and approved the information included in this submission.

Signature of visit clinician (Required):_____

Signature of supervising physician (Required if patient seen by an APP):_____