

PATIENT QUESTIONNAIRE FOR LUMBAR SPINAL CONDITIONS

It is important that each question be answered as fully as possible. Incomplete answers may result in denial of some of your treatment options by your insurance company.

SYMPTOMS:

1. How long have you experienced back pain? _____
2. Does your pain radiate into one or more of your lower extremities? (legs, feet) ___yes ___no
3. Are you experiencing weakness in any lower extremity? (legs, feet) ___yes ___no
If yes, please indicate right, left, or both _____ For how long? _____
4. Is your back pain made worse by walking or prolonged standing? ___yes ___no
Does your pain lessen when you bend forward at the waist? ___yes ___no
5. Does your back pain come and go, or is it constant? _____
6. Are you experiencing bladder or bowel instability (such as urinary incontinence)? ___yes ___no
If yes, what symptoms are you having? _____
For how long? _____

HISTORY:

1. Is your pain level affecting your lifestyle/abilities to perform daily living activities: (e.g. inability to perform household chores, interference with essential job functions, prolonged standing, etc.)
___yes ___no
If yes, please explain: _____

2. What adjustments have you made in order to help you in the performance of your daily living activities?
Please check all that you have tried and for how long:
___ Rest ___3 ___6 ___12 months ___longer
___ Structured physician supervised exercise program
including core stabilization exercises (back and
abdominal muscles) ___3 ___6 ___12 months ___longer
___ Avoid activities that aggravate your pain ___3 ___6 ___12 months ___longer
___ Application of heat/cold to affected area ___3 ___6 ___12 months ___longer
___ Localized injections such as trigger point or
epidural injections ___3 ___6 ___12 months ___longer
___ Chiropractic manipulation ___3 ___6 ___12 months ___longer
___ Physical therapy ___3 ___6 ___12 months ___longer
___ Other; please describe: _____

3. Do you have unremitting back pain that has failed to improve despite at least 6 months of conservative (non-surgical) treatment measures? ___yes ___no

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4. Have you had previous back surgery(ies)? yes no
If yes, please list type of surgery(ies) and when: (Please include which spinal levels were operated, e.g. L1-L2, L3-L4, etc.) _____

Did you initially improve following this/these procedures? yes no
For how long? _____

5. Have you undergone a course of nonsteroidal (NSAIDs) or steroidal medications? yes no
If yes, for how long? _____

6. Have you been advised to undergo a weight loss program for your back problems? yes no
not overweight

7. Do you use an assistive device such as a cane, crutches, walker, etc? yes no

8. Have you ever worn a back brace for your back problem? yes no
If yes, when and for how long? _____

9. If you have undergone conservative treatment (non-surgical) for your current condition (such as physical therapy, treatment by a pain management specialist, injections, chiropractic, etc, by whom were you treated and when?

Providers:

Dates:

From: _____ To: _____
From: _____ To: _____
From: _____ To: _____
From: _____ To: _____
From: _____ To: _____

10. Do you currently smoke cigarettes? yes no
If you currently smoke, have you been advised to stop? yes no
Are you now in a smoking cessation program? yes no
If you currently use tobacco products, do you agree to stop at least 6 weeks prior to surgery in the event a spinal fusion is planned? yes no

*** Patients who smoke are advised to stop at least 6 weeks before a planned surgery that involves a spinal fusion. Studies have demonstrated that the rate of non-fusion in smokers is as much as twice that of non-smokers due to the negative effects of nicotine on bone growth.**

*** Most insurance companies will not grant authorization for spinal fusion procedures unless tobacco use has been stopped for a minimum of 6 weeks prior to the surgery.**

***Note: Prior to authorizing lumbar spinal fusion surgery, some insurance companies may require the following:**

A. A statement from your primary care doctor, neurologist, physiatrist, psychiatrist or psychologist that there is no psychological condition contributing to the individual's chronic pain.

AND

B. A statement from a behavioral therapist confirming the individual has completed a course of cognitive behavioral therapy (e.g.: 8-10 sessions) that is problem-focused and action-oriented.

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