



THORACIC/LUMBAR/SACRAL CLINICAL QUESTIONNAIRE

NAME: _____ DATE: _____

1. Why has your doctor sent you for this test? Did he/she give you a specific diagnosis?

2. Please describe what specific complaints/symptoms have been most bothersome to you?

3. How long have you had these complaints/symptoms? _____

4. Did these complaints/symptoms come on suddenly or gradually? _____

5. Are these symptoms the: same better worse

6. Do you have back pain? yes no

7. Do you have pain, numbness, weakness or tingling in any of the following areas:

	Right	Left
Buttock	<input type="checkbox"/>	<input type="checkbox"/>
Front of Thigh	<input type="checkbox"/>	<input type="checkbox"/>
Back of Thigh	<input type="checkbox"/>	<input type="checkbox"/>
Calf/Shin	<input type="checkbox"/>	<input type="checkbox"/>
Near Big Toe	<input type="checkbox"/>	<input type="checkbox"/>
Near Small Toe	<input type="checkbox"/>	<input type="checkbox"/>

8. Do you have bowel and/or bladder problems? yes no

9. Have you had a prior significant injury to your neck/spine? yes no

If yes, please describe: _____

10. Do you have a history of cancer? If so, what type? _____

11. Have you had prior surgery of your neck/spine? yes no

If yes, please describe: _____

