Back disorder questionnaire - Physician

Full name of applicant

1. Please state the precise diagnosis.

2. Site:
   a) What part of the back is/was affected?

   b) Were there any neurological abnormalities such as numbness or incontinence or has any other organ or system been affected? If so, please provide full details.

3. Frequency of symptoms:
   a) When was the first episode?

   b) When was the last episode?

   c) How frequently do symptoms occur? i.e. how many episodes in the last 24 months?

4. Cause and impact of symptoms:
   a) Please advise dates and durations of any time off work due to back pain in the last two years.

   b) Please estimate total time off work as a result of the back disorder.

   c) Does the patient's job include any duties which may exacerbate the back disorder? Yes ☐ No ☐
   If YES, please give full details.

   d) Has the patient changed jobs or adjusted duties in any way because of their back? Yes ☐ No ☐
   If YES, please advise full details.

5. Medical care:
   a). Has the patient undergone any investigations such as X-rays, CT scan, MRI, etc? Yes ☐ No ☐
   If YES, please provide full details including the dates and results.

   b) Has surgery been carried out, or is surgery being considered? Yes ☐ No ☐
   If YES, please provide dates and full details including names of hospital and surgeon and how long after the operation was it before they were able to return to work.

   c) Does the patient require, or use, pain killers for back related symptoms? Yes ☐ No ☐
   If YES, please provide names of drugs, dosage and when last taken.

   d) Has any other form of treatment been prescribed, e.g. anti-inflammatory treatment, physiotherapy, chiropractic or osteopathic manipulation, etc.? Yes ☐ No ☐
   If YES, please provide full details and dates and advise if such treatment is still being received.

6.. Please give details of current symptoms, if any.

7. Have there been any episodes of associated anxiety or depression? If so, please give details.

Signature

Date

Please print name and add clinic stamp