

***Patient assessment questionnaire -
Lumbar Spine***

**Auckland Neurosurgical Clinic
Ltd**

Name:	Sex: Male / Female		
Date of Birth	E-mail Address:		
Address:			
Telephone number: (day)		(evening)	
GP Name & Address:			
Insurers name and address:			
		Postcode:	
ACC Number:		Case Manager	

	(Please circle)		
1. Do you have pain?	Yes	No	
2. Have you had similar pain in the past?	Yes	No	
3. When did the current problems start?			
4. Do you have numbness?	Yes	No	
5. Do you have pain in the thigh?	Yes	No	
6. Which side?	Right	Left	
7. Do you have pain going down below the knee into the ankle or foot?	Yes	No	
8. If you have pain below the knee, is it in the right leg only, the left leg only or both?	Right	Left	Both
9. Do you have tingling or numbness in either leg or foot?	Yes	No	
	Right	Left	Both
10. Do you have any weakness, clumsiness of the foot or leg?	Yes	No	
	Right	Left	Both
11. Have you had an operation in the past?	Yes	No	
What operation was performed?			
Date and place of surgery:			
12. Have you had any illnesses in the past?	Yes	No	
If yes please list-			
13. Medication			
Aspirin	Yes	No	Plavix (Clopidogrel)
Warfarin	Yes	No	Yes
			No