Patient assessment questionnaire
The Thoracic spine

Auckland Neurosurgical Clinic Ltd

Name:	Male/Female (please delete)
Date of birth:	E-mail Address:
Address:	
	Postcode:
Telephone number: (day)	(evening)
Doctor's name and address:	
	Postcode:
Insurers name and address:	
	Postcode:
ACC Number	Case Manager

		(please circle)		
1.	Do you have back 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 pain in the side of the chest or shoulders?	Yes		No
5.	Do you have pain in the stomach?	Yes		No
	If so which side?	Right	Left	Both
6.	Do you have tingling or numbness in either legs?	Yes		No
7.	Do you have any weakness, clumsiness in the legs?	Yes		No
	If so which side?	Right	Left	Both
8.	Do you have any stiffness of the legs?	Yes		No
	If so which side?	Right	Left	Both
9.	Do you have any spasms in the legs?	Yes		No
	If so which side?	Right	Left	Both
10.	Are you incontinent of urine?	Yes		No
11.	Have you had an operation on the spine 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-			
	Have you had any operations in the past?	Yes		No
	If yes please list-			

13. Medication

Aspirin	Yes	No	Plavix(Clopidogrel)	Yes	No
Warfarin	Yes	No			