Lumbar Spine Surgical Screening Patient Questionnaire

Fax: 289.479.0188
Phone: 289.235.8800
560 North Service Road, Grimsby, L3M 0G3

WATERVIEW
Physiotherapy & Health Centre

Please complete as much as possible

Patient Name: _____ Date: _____

Date of Birth: _____

Health Card #: _____

Home Address: _____

Home Telephone: _____ Work Telephone: _____ Cell: _____

WSIB Claim Number (if applicable): _____

Family Physician: _____ Referring Physician: _____

Please circle whether you are: single married widowed divorced common-law

Do you have children? Please circle: none young children adult children

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Main Complaint: _____

_____

Are you right or left handed?: _____ Your height and weight: _____

Are you currently employed?: Yes No (please provide more details below)

If **yes**, what is your current occupation?: _____

If **no**, on what date did you stop working?: _____

Have you had any past health issues? Please explain: _____

_____

Have you had any previous operations? Please explain: _____

_____

Are there any serious health issues in your family?: _____

Are there any medications you are allergic to?: _____

Are you currently taking presciption medications? Please list: _____

_____

Are you a smoker?: Yes No For how many years?: _____ How many cigarettes per day?: _____

Do you consume alcohol?: Yes No How many alcoholic beverages do you consume per week?: _____

What hobbies/interests do you have outside of work?: _____

_____

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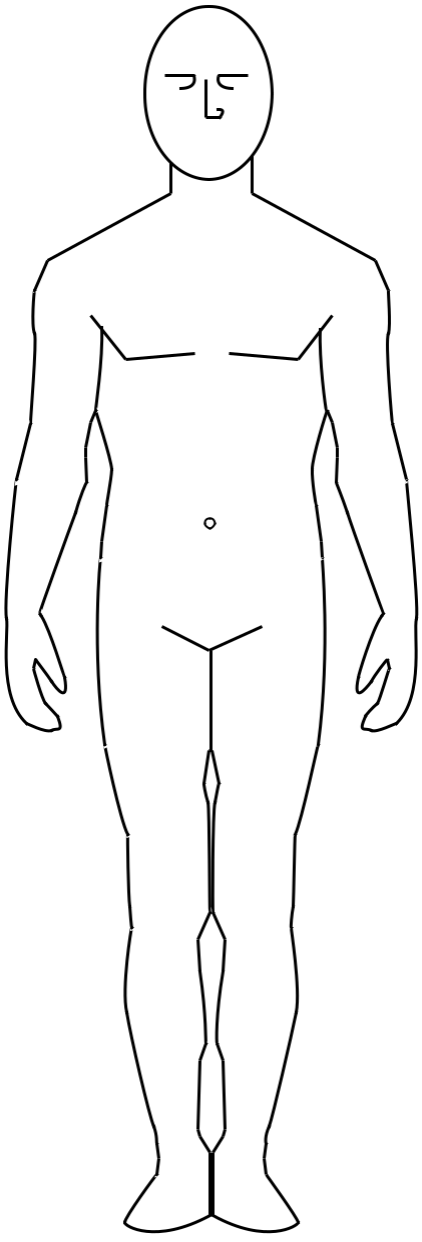
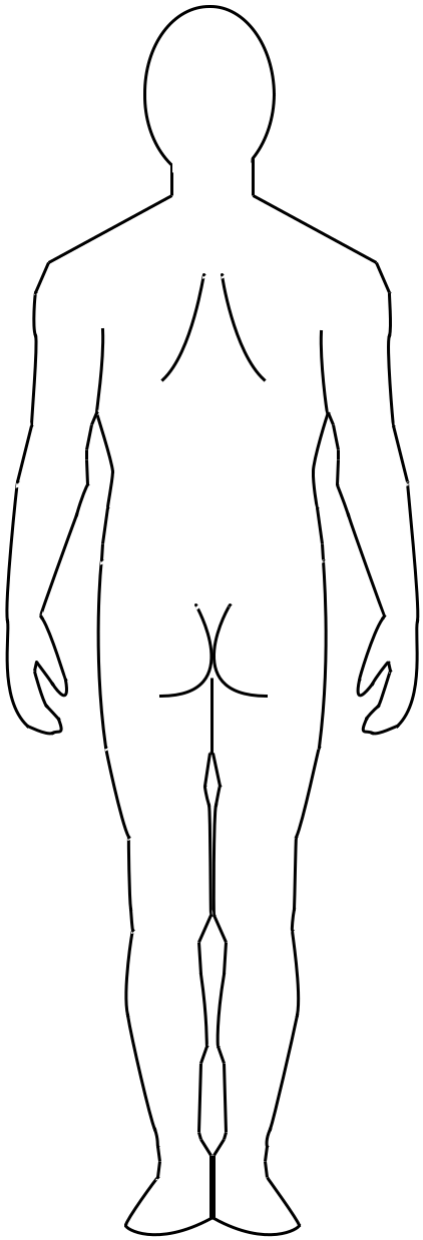
Patient Name: _____

If you are experiencing pain, numbess and/or weakness, use the diagrams below to circle the locations.
Please describe the type of pain or sensation in the area.



Front



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