

SPINAL QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Have you ever had pain in your back, neck or shoulder? Yes ___ No ___ If yes, complete the following:
 - a. How many times: _____
 - b. Date of first episode: _____
 - c. Date of last episode: _____

2. What area(s) involved? (circle appropriate areas)
Neck (cervical) Middle (thoracic) Low (lumbosacral)
 - a. Does the pain radiate? Yes ___ No ___ If yes, where? _____
 - b. Give definitive diagnosis, if known _____

3. Is this a disc disorder? Yes _____ No _____ If yes, indicate type:
_____ Herniation _____ Rupture _____ Protrusion

4. Was this the result of an injury? Yes _____ No _____ If yes, provide details _____

5. Have you ever been diagnosed with Scoliosis? Yes _ No ___ If yes, degree of curvature _____

6. Due to back pain, do you take prescription medication? Yes _____ No ___ If yes, provide the following:
Name of Medication **Dosage:** **Frequency/Date last taken:**

- a. Have you ever had or been advised to have surgery/or spinal fusion? Yes _____ No _____
If yes, provide details: _____

- b. Have you ever had or now have chiropractic treatment or physical therapy for your back?
Yes ___ No _____ If yes, how often? _____ Date last seen? _____

- c. Have you ever had loss of time at work or restriction of activities? Yes _____ No _____
If yes, how long were you off work? _____
When did you return to work? _____

7. What is the current status of your back, neck or shoulder pain? _____

8. Name and address of treating physician: _____

9. What is your current height _____ Weight? _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date