


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

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