Decompression Consultation Questionnaire

Name _____ Date _____

Exclusion Criteria – Do you currently have any of the following conditions?

Y	N	Pregnant	Y	N	Pars Defect
Y	N	Prior Lumbar Fusion	Y	N	Pathologic Aorta Aneurysm
Y	N	Metastatic Cancer	Y	N	Pelvic or Abdominal Cancer
Y	N	Hemiplegia Paraplegia	Y	N	Cognitive Dysfunction
Y	N	Severe Osteoporosis	Y	N	Disc Space Infection
Y	N	Spondylolisthesis (unstable)	Y	N	Severe Peripheral Neuropathy
Y	N	Compression Fracture of Lumbar Spine Below L-1 (recent)	Y	N	Loss of Bladder or Bowel Control

Reason for this visit: _____

_____

How often do you feel the pain? ☐ Occasionally ☐ Intermittently ☐ Frequently ☐ Constantly

Did it appear: ☐ Immediately or ☐ Slowly over: ( )Weeks ( )Months ( )Years

What aggravates your condition? Prolonged Sitting Standing Walking Running Driving Bending

Other: _____

Does any position relieve the pain? _____

Type of Pain: ☐ Sharp ☐ Dull ☐ Stiffness ☐ Swelling

Is pain interfering with : ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Have you had back or hip surgery? Yes No When? _____

Ever had epidurals or spinal injections? Yes No When? _____

Do you have any spinal fusions? Yes No Where? _____

Do you have any metal in your back? Yes No Where? _____

Other doctors seen for this condition? _____

Medications taken for this condition? _____

Have you had an **MRI** for this condition? Yes No Date of MRI: _____

Primary Care Physician _____ Phone: _____

Signature_____