

**Lumbar Spine and Lower Extremity Questionnaire:**

Please Answer the questions to the best of your ability in order for us to be of help to you.

Describe your present symptoms: \_\_\_\_\_

When did the symptoms start? \_\_\_\_\_

How/Why did the Symptoms start? \_\_\_\_\_

What was the first Symptom you felt? \_\_\_\_\_

Are the Symptoms there **ALL** the time? Or are there times in the day/night when they are not present? \_\_\_\_\_

Does the pain disturb your sleep? \_\_\_\_\_ If yes, does it keep you from getting to sleep or wake you up from sleep? \_\_\_\_\_ If it wakes you, how long are you asleep generally before it wakes you? \_\_\_\_\_

Does it increase the symptom when you (circle if Yes, cross out if No): Cough Sneeze Strain

Have you had any change in your bladder function with this episode? \_\_\_\_\_

Have you had an issue with bladder or bowel function not related to this episode? \_\_\_\_\_

Have you had any weakness in your Knee or foot? \_\_\_\_\_

Have you had any unexplained weight loss? \_\_\_\_\_

**Please put a "B" for Better, "W" for Worse and "N" for No Effect beside each of the following activities: This is a very helpful component of the evaluation.**

Bending \_\_\_\_\_ sitting \_\_\_\_\_ Rising from sitting \_\_\_\_\_ Standing \_\_\_\_\_ Walking \_\_\_\_\_ Moving \_\_\_\_\_  
Lying \_\_\_\_\_ First thing in the AM \_\_\_\_\_ As the day progresses \_\_\_\_\_ In the PM \_\_\_\_\_ Rolling in bed \_\_\_\_\_

Is there anything that relieves the symptoms? Meds/heat etc \_\_\_\_\_

Have you had a recent or a significant fall? \_\_\_\_\_

Have you had back Surgery? \_\_\_\_\_ Epidural Injections? \_\_\_\_\_

Have you experienced these symptoms before? \_\_\_\_\_ When? \_\_\_\_\_

Have you been treated for this previously? \_\_\_\_\_ Was it helpful? \_\_\_\_\_

Is there anything else you believe it would be important for me to know? \_\_\_\_\_

*Thank You! Marjorie R. Rodd P.T., Cert. MDT*