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SPINAL PROGRAMME QUESTIONNAIRE

All sections must be completed by the patient. For minor children, the responsible adult needs to complete and sign.
Please submit the completed form along with supporting documentation to email: spinal@rxhealth.co.za

A. PATIENT DETAILS (ALL FIELDS ARE MANDATORY)

Patient Name and Surname																	
Membership Number										Patient Date of Birth	Y	Y	Y	Y	M	M	D	D
Patient Age				Weight (in kg)				Height (in cm)						If unsure of your weight and height, visit a pharmacy for assistance.			
Employer Group								Current Occupation									
How long have you been in this occupation?																	

B. TELL US MORE ABOUT YOUR PAIN (Please provide details – what happened and when did it happen? 'Tick' or answer 'Y' or 'N' below)

1. When did your current pain start?

	Less than 14 days ago		More than 14 days but less than 1 month ago
	1 – 6 months ago		More than 6 months ago

2. How severe (bad) is your pain?

	I have no pain at the moment.		The pain is fairly severe at the moment.
	The pain is very mild at the moment.		The pain is very severe at the moment.
	The pain is moderate at the moment.		The pain is the worst imaginable at the moment.

3a. Have you suffered from a previous spine injury?	Y	N													
Date of Previous Injury	Y	Y	Y	Y	M	M	D	D	Hospital/Medical Facility						
Treating Doctor/Surgeon															
3b. Have you had previous spine surgery?	Y	N													
Date of Previous Operation	Y	Y	Y	Y	M	M	D	D							

3c. If 'Yes', where?		Back		Neck

3d. If 'Yes', please indicate what type of surgery you have had

	Decompression		Decompression and fusion		Infiltration
Other, please specify					

3e. Possible cause of spine injury/condition:

	Motor Vehicle Accident		Fall or Slip		Workplace Injury
Other, please specify					

3f. Have you had any scans of your back or neck in the past?	Y	N

Describe your symptoms (Please 'tick' or answer 'Yes' or 'No' for the option that relates to you)**:**

Walking

☐	Pain does not prevent me from walking any distance.	☐	Pain prevents me from walking more than 1 kilometre.
☐	Pain prevents me from walking more than 500 metres.	☐	Pain prevents me from walking more than 100 metres.
☐	I can only walk using a stick or crutches.	☐	I am in bed most of the time and have to crawl to the toilet.

Standing

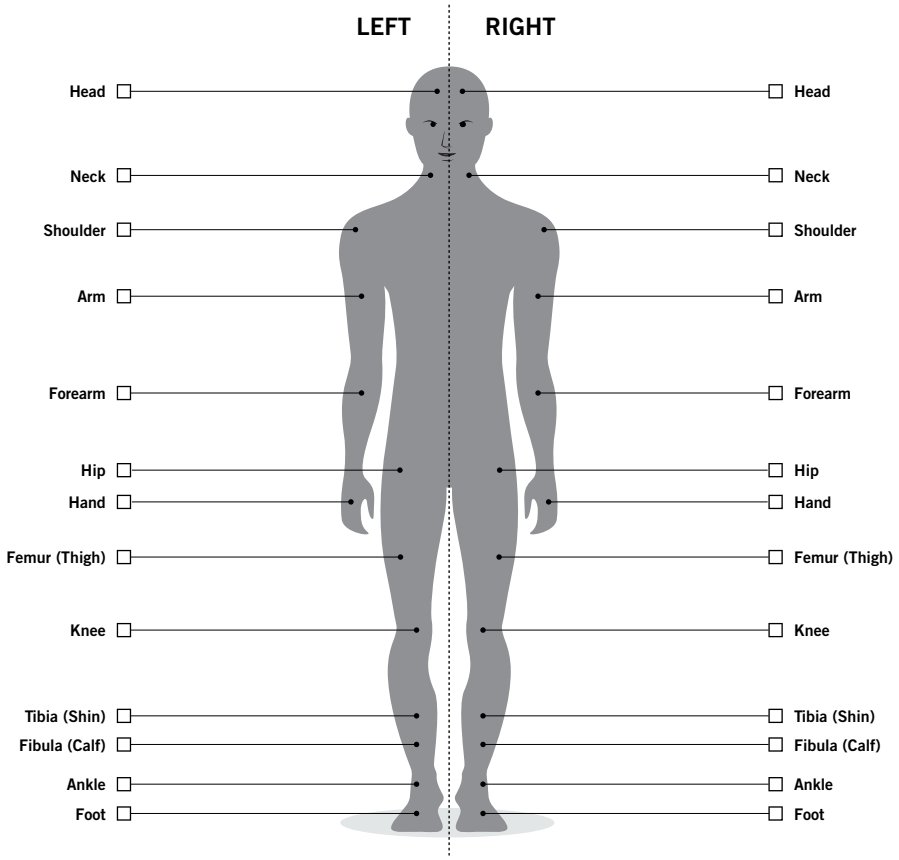
☐	I can stand as long as I want without extra pain.	☐	I can stand as long as I want, but it gives me extra pain.
☐	Pain prevents me from standing for more than 1 hour.	☐	Pain prevents me from standing for more than ½ an hour.
☐	Pain prevents me from standing for more than 10 minutes.	☐	Pain prevents me from standing at all.

Sleeping

☐	My sleep is never disturbed by pain.	☐	My sleep is occasionally disturbed by pain.
☐	Because of pain, I get less than 6 hours of sleep.	☐	Because of pain, I get less than 4 hours of sleep.
☐	Because of pain, I get less than 2 hours of sleep.	☐	Pain prevents me from sleeping at all.

Do you have sensations of tingling, numbness, or "pins and needles" in certain parts of your body?	Y	N
Do you experience weakness or reduced strength in your limbs (arms or legs), hands, fingers or feet?	Y	N
Have you recently developed bladder problems or faecal incontinence?	Y	N

Please indicate where your symptoms are located (use the diagram provided and mark):



What makes your pain better?

☐	Bending forward	☐	Standing up straight	☐	Lying down

If you answered 'Yes' to the questions above, please tell us how often you experience these symptoms?

☐	Every day	☐	A few times a week	☐	Rarely	☐	Never

We used The Qswestry Questionnaire to assess patient risk.

C. TESTS CONDUCTED

Please tell us which tests you have done by 'ticking' the relevant test:				
	Spinal X-rays	Report included	Y	N
	Anterior/Posterior View	Report included	Y	N
	Lateral View	Report included	Y	N
In the case of lower back pain, did you have any of the following?				
	Flexion/extension of lower back	Report included	Y	N
	Bilateral hip X-rays	Report included	Y	N

Have you had any blood tests done?	Y	N	Report included	Y	N
Was an EMG (Electromyography or Nerve Study) test performed?	Y	N	Report included	Y	N

D. THE Keele STarT BACK SCREENING

Thinking about the last 2 weeks, tick your response to the following questions:	Agree	Disagree
1. My back pain has spread down my leg(s) at some time in the last 2 weeks.		
2. I have had pain in the shoulder or neck at some time in the last 2 weeks.		
3. I have only walked short distances because of my back pain.		
4. In the last 2 weeks, I have dressed more slowly than usual because of back pain.		
5. It's not really safe for a person with a condition like mine to be physically active.		
6. Worrying thoughts have been going through my mind a lot of the time.		
7. I feel that my back pain is terrible and it's never going to get any better.		
8. In general, I have not enjoyed all the things I used to enjoy.		

9. Overall, how bothersome has your back pain been in the last 2 weeks?

	Not at all		Slightly		Moderately		Very much		Extremely

E. CURRENT TREATMENT

Please list all current and chronic medications that you are taking:	
For Pain	
For Hypertension (high blood pressure)	
For Diabetes Mellitus (Sugar Diabetes)	
For HIV	
For Hyperlipidaemia (high cholesterol)	
For Renal Failure	
For Prostate Problems	
For Gynaecological Problems	
State any other medications you take daily	

We used The Qswestry Questionnaire to assess patient risk.

E. CURRENT TREATMENT (CONTINUED)

Other treatments:		
Psychologist/Psychiatrist	Y	N
Spinal Rehabilitation Programme	Y	N
Physiotherapy	Y	N
Biokinetics	Y	N

If 'Yes', please include a report from the healthcare provider.

F. ADDITIONAL INFORMATION

Please indicate 'Yes' or 'No':		
Have you ever been diagnosed with cancer? Or are you currently being treated for cancer?	Y	N
Have you experienced recent weight loss?	Y	N
Are you feverish?	Y	N
Do you use any injectable medicine and/or drug?	Y	N
Have you had a recent epidural or spinal procedure?	Y	N
Have you ever been treated for or currently receiving treatment for TB?	Y	N
Do you smoke cigarettes?	Y	N

G. WHO IS YOUR TREATING DOCTOR/GENERAL PRACTITIONER?

Full Name and Surname of your Doctor			
Practice Number		Contact Number	
E-mail Address			
Practice Physical Address			

H. DECLARATION (TO BE COMPLETED BY THE PATIENT)

I, _____ (Name and Surname), with Umvuzo Health membership number ☐☐☐☐☐☐ hereby confirm that all the information provided within this form is true and accurate.

I acknowledge and understand that spinal and back procedures and treatment plans, in accordance with Clause 1.29 in Annexure C (Exclusions and Limitations) of the Umvuzo Health Scheme Rules, are subject to the Umvuzo Health Spinal Programme, its Funding Guidelines, criteria and processes. Any services outside of the parameters of the Umvuzo Health Spinal Programme are excluded from benefits.

I give consent to Umvuzo Health and its representatives to obtain X-rays, scans and ultrasound images from the relevant radiology practices.

I understand that Umvuzo Health Medical Scheme has an agreement with a Secondary Referral Centre to evaluate all clinical information received from my treating specialist and that participation and/or benefits on the Spinal Programme are not guaranteed.

_____

Signature

Date Y Y Y Y M M D D

Contact Number | E-mail Address