BACK QUESTIONNAIRE

Patient Name: _____ DOB: _____

1.) Describe your distribution of pain (i.e., low back, buttock, front/back of thigh, calf, ankle, foot, toes). Be specific.

_____
_____

2.) Do you have numbness/tingling? Does it radiate in the same distribution? Be specific.

_____
_____

3.) Is this work comp? Yes No Litigation pending? Yes No

4.) What is your job description?

_____

___ hrs/day, ___ days/week What is your current job status? _____

5.) When did you hurt your back? _____

6.) Where were you, and what were you doing, when you injured your back?

_____

7.) Rate your pain (0 for no pain, 10 for most pain): ___\10

8.) Describe your pain (circle all that apply):

sharp dull stabbing burning throbbing aching

9.) When is the pain the worst? Do you have pain at night or at rest? Be specific.

_____

10.) What makes the pain worse (circle all that apply)?

Standing walking lying in bed coughing sneezing lifting
bending sitting sneezing changing from sitting to standing

Other: _____

11.) What improves your pain (circle all that apply)?

Rest ice heat standing sitting Ibuprofen/Aleve Tylenol

Other: _____

12.) Do you have any of the following (circle any that apply)?

History of cancer unexplained weight loss current infection/immune suppression
Traumatic injury bowel/bladder dysfunction major motor weakness

13.) Do you have any other symptoms? Be specific.

_____

14.) Do you smoke? Yes No If yes, ___ packs/day x ___ years

15.) Do you drink regularly? Yes No If yes, ___ drinks/day x ___ years

16.) Do you have history of prior back surgery? Yes no

17.) Do you have prior history of back pain? Yes no In last 3 months? Yes no

If yes, describe your prior treatment rendered by a physician

_____

18.) Did the treatment help? Yes No

19.) Have you had any x-rays/MRI/CT or other prior imaging studies? Yes No

If yes, what study and where was it performed?

_____

I certify that I have read and understand the above information to the best of my knowledge, and that the above questions have been acurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the physician to release any information including the diagnosis and the records of any treatment or examination rendered to third party payors and/or health practicioners. I authorize and request my insurance company to pay directly to the physician insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature	MD/PA Signature	Date

Recall Review Signatures: Date:

1			
2			
3			
4			
5			
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