BACK QUESTIONNAIRE

Patient Name: _____ DOB: _____

1.) Where does your back hurt? _____

2.) Is this a new presentation of back pain, or a follow-up?_____

3.) Did another provider refer you? If yes, who?_____

4.) Describe **how** and **where** your symptoms occurred/how you injured your back? Be specific (include **dates**)

_____

_____

5.) Describe the timing of your pain? (check all that apply)

__constant __worse at the end of the day __worse during the night
__intermittent __worse during activity __worse during the morning
__worse after activity __worse during the day other:_____

6.) What best describes your back pain? (check all that apply)

__aching __cramp-like __radiating to right foot
__catching __dull __radiating to toes of left foot
__clicking __radiating __radiating to toes of right foot
__pins and needles __radiating to above the left knee __sharp
__popping __radiating to above the right knee __stabbing
__shooting sensation __radiating to below the left knee __worse with extension
__stiffness __radiating to below the right knee __worse with flexion
__burning __radiating to left foot other:_____

7.) What is associated with your back pain? (check all that apply)

__flank pain on the left __pain in the right buttock
__flank pain on the right __pain in the right lateral thigh
__neck pain __tingling in the left lower extremity
__numbness in the left lower extremity __tingling in the right lower extremity
__numbness in the right lower extremity __weakness in the left lower extremity
__pain in the left buttock __weakness in the right lower extremity
__pain in the left lateral thigh other:_____

8.) What aggravates your back pain? (check all that apply)

__all movement __lifting objects __walking for long distances
__bending over __lying flat other:_____
__exercise __standing for prolonged periods

9.) How severe is the pain on a scale of 0-10? (0 = no pain 10= worst pain)

currently ___ /10 on a bad day ___ /10 on an average day ___ /10
initially ___ /10 on a good day ___ /10

10.) How severe if your leg pain on a scale of 0-10? (if applicable) ___ /10

11.) How long have you had your back pain? ___years ___months ___weeks ___days

12.) What are you currently using to treat the back pain? (check all that apply)

__activity modification __injections __pilates __no treatment
__brace __medications __weight reduction other:_____
__chiropractic treatments __physical therapy __yoga

13.) Have you had any procedures or surgeries to treat the back pain? If yes, what type?

_____

14.) What diagnostic imaging studies have you had for this problem? (check all that apply)

__bone scan __EMG __plain radiographs (X-ray) other:_____
__CT scan __MRI __no imaging studies

15.) How has this problem limited you? (check all that apply)

__attending school on a limited basis __difficulty with REC sports participation
__difficulty getting up from a chair __functional limitations __requiring occasional assistance
__difficulty sitting __inability to attend school __working light duty
__difficulty standing __inability to perform ADL's __working on a limited basis
__difficulty walking __inability to work __no limitations
__difficulty with ADL's __requiring constant assistance other:_____

16.) Who have you seen for this problem? (check all that apply)

__ER __another doctor __therapist __trainer __urgent care __walk-in clinic other:_____

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		
6		
7		