BACK PAIN QUESTIONNAIRE
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Name: ____ Date: ________________

Age: __________ Sex: ❑ Male ❑ Female Occupation: ______________________________

Job description: ____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Major complaint: ____

____

1. How long have you had back pain? ____

2. If you get leg pain:

   How long have you had leg pain? ____

   Which pain is worse? ❑ Back ❑ Leg ❑ Equal

   Which leg gives you pain? ❑ Right ❑ Left ❑ Both

   Which leg is worse? ❑ Right ❑ Left ❑ Both

3. Date your present pain began? ____

4. Describe the mechanism of injury or how the pain began: _______________________

   ____

   ____

   ____

5. If the injury was from an automobile accident:

   Date of the accident? ____

   Were you the driver or a passenger? ____

   Were you wearing a seat belt? ❑ Yes ❑ No

   How was your car hit? ❑ Struck from behind ❑ Right side ❑ Left side ❑ Head-on

   How fast was your car traveling? ____

   How fast was the other car traveling? (if applicable) ____________________

   How much damage was done to your car? $ ____________

6. Is your pain getting? ❑ Better ❑ Worse ❑ Staying the Same

7. Have you ever had back problems before? If so, please describe: _______________

   ____

8. Do you have weakness in your leg? ❑ Yes ❑ No

   How do you notice the leg weakness?

   ❑ Walking short distances ❑ Walking long distances ❑ Walking stairs ❑ Leg giving way

   ❑ Other: ____

9. How far can you walk without leg pain?

   ❑ Less than 1 block ❑ Less than 2 blocks ❑ Less than 5 blocks ❑ ½ mile or longer

10. If you get leg pain with walking, what do you do to relieve it?

❑ Stand ❑ Sit ❑ Bend forward ❑ Use a walker or cane ❑ Lean on a shopping cart

11. Have you had trouble starting or holding your urine? ❑ Yes ❑ No

If yes, please describe: ______________________________

Have you had trouble starting or holding your bowels? ❑ Yes ❑ No

If yes, please describe: ______________________________

12. Prior treatments for your back:

What physicians have you seen for your back? ______________________________

____

Have you taken any of the following? If yes, please describe:

Anti-inflammatory? ❑ Yes ❑ No ______________________________

Muscle relaxants? ❑ Yes ❑ No ______________________________

Pain killers? ❑ Yes ❑ No ______________________________

Have you had any of the following treatments?

❑ Physical therapy ❑ Exercise program ❑ Epidural blocks or injections

❑ Bed rest ❑ TENS unit ❑ Chiropractic ❑ Brace

❑ Other: ______________________________

Have you had spine surgery? ❑ Yes ❑ No If yes, how many times?

Please provide information about your back surgeries:

Type of operation	Date	Doctor's name and city	Duration of improvement	Returned to work for how long?

Please rate your pain overall:

1 2 3 4 5 6 7 8 9 10

No Pain *Moderate Pain* *Severe Pain*

Patient's Name: ______________________________ Chart Number: __________________

13. What activities make the pain worse?

❑ Sitting ❑ Walking ❑ Standing ❑ Riding in a Car ❑ Coughing
❑ Sneezing ❑ Lifting ❑ Bending forward ❑ Bending backward
❑ Other: ______________________________

14. What activities reduce the pain?

❑ Lying down ❑ Hot baths ❑ Brace ❑ Heat ❑ Massage
❑ Other: ______________________________

15. Are there any activities you can not do because of your pain?

❑ Dress without assistance ❑ Go out socially ❑ Fix a meal independently ❑ Lift
❑ Make a bed ❑ Grocery shop ❑ Walk around a mall ❑ Vacuum
❑ Carry a laundry basket ❑ Shovel snow ❑ Push a lawnmower ❑ Participate in sports
❑ Other: ______________________________

16. About your work:

Have you missed work due to your pain? ❑ Yes ❑ No
Are you currently working? ❑ Yes ❑ No If yes, are you on: ❑ Light duty ❑ Regular duty
If you are not back to work, what date did you last work? ______________

17. Have you had any of the following diagnostic studies?

X-rays	❑ Yes ❑ No	If yes, when?	______________
MRI	❑ Yes ❑ No	If yes, when?	______________
CAT Scan	❑ Yes ❑ No	If yes, when?	______________
Myelogram	❑ Yes ❑ No	If yes, when?	______________
EMG	❑ Yes ❑ No	If yes, when?	______________
Discogram	❑ Yes ❑ No	If yes, when?	______________

18. Do the following apply?

Workers' compensation?	❑ Yes	❑ No
Legal proceedings?	❑ Yes	❑ No
Disability?	❑ Yes	❑ No

If an attorney is involved, please provide the following information:

Name: ______________________________

Address: ______________________________

Telephone: ______________________________

Medical History (please check all that apply) **Major Illnesses? ❑ Yes ❑ No**

Diabetes (Insulin? ❑ Yes ❑ No)	❑ Yes	❑ No	Heart problems (explain below)	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No
Gout	❑ Yes	❑ No	Tuberculosis (TB)	❑ Yes	❑ No
Cancer (explain below)	❑ Yes	❑ No	AIDS (HIV or ARC)	❑ Yes	❑ No
High blood pressure	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No
Emphysema / Bronchitis	❑ Yes	❑ No	Thyroid (low or high)	❑ Yes	❑ No
Asthma / Shortness of Breath	❑ Yes	❑ No	Kidneys	❑ Yes	❑ No
Stomach ulcers	❑ Yes	❑ No	Bleeding problems	❑ Yes	❑ No
Blood clots	❑ Yes	❑ No	Chest pain	❑ Yes	❑ No

Other: ______________________________

Please list family members having any of the diseases listed above, and also list the disease:

Father: ______________________________

Mother: ______________________________

Siblings: ______________________________

Grandparents: ______________________________

____

____

List any surgeries that you have had that were not related to your back/spine:

______________________________ When? __________

______________________________ When? __________

______________________________ When? __________

______________________________ When? __________

List all medications that you currently take:

______________________________ Dosage __________

______________________________ Dosage __________

______________________________ Dosage __________

______________________________ Dosage __________

______________________________ Dosage __________

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______________________________ Dosage __________

______________________________ Dosage __________

______________________________ Dosage __________

List your allergies: ______________________________

____

____

Are you allergic to metals? ❑ Yes ❑ No

Have you ever smoked cigarettes? ❑ Yes ❑ No Number of packs per day __________

If you quit, when? ______________________________

Do you drink alcoholic beverages? ❑ Yes ❑ No How much? __________

Patient's Name: ______________________________ Chart Number: __________

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

How many children do you have? ______________________________

What is your level of education?

❑ Grade school ❑ High school ❑ Vocational School

❑ Technical school ❑ College ❑ Graduate education

List your sports activities and your hobbies: ______________________________

____

Employment: ❑ Full time ❑ Part time Hours per week: ____________ ❑ Retired

Your height: ______________ Your weight: ______________

Please check all that apply:

❑ Fevers	❑ Sore throats	❑ Diarrhea
❑ Chills	❑ Loss of energy	❑ Blood in stools
❑ Night sweats	❑ Depression	❑ Urinary burning
❑ Weight loss	❑ Thoughts of suicide	❑ Urinary discharge
❑ Skin disorders	❑ Chest pain	❑ Headaches
❑ Eye problems	❑ Cough	❑ Change in appetite
❑ Ear problems	❑ Breathing trouble	❑ Sleeping difficulty
❑ Nosebleeds	❑ Breast mass	❑ Need to see a psychiatrist
❑ Sinus trouble	❑ Breast discharge	❑ Problems tolerating hot or cold

For Women:

Date of last normal menstrual cycle: ______________________________

Irregular? ❑ Yes ❑ No Age of menopause: ______________

If postmenopausal or ovaries have been removed, are you on an estrogen supplement?

❑ Yes ❑ No Date of ovary removal: ______________

Have you had a bone density test? ❑ Yes ❑ No

Have you taken Estrogen in the past? ❑ Yes ❑ No If yes, how long?______________

Are you taking any of the following?

Calcium	❑ Yes	❑ No
Vitamin D	❑ Yes	❑ No
Fosamax	❑ Yes	❑ No
Actonel	❑ Yes	❑ No
Boniva	❑ Yes	❑ No

Symptoms

Using the following keys, indicate on the drawing the location and type of pain or abnormal sensations you are experiencing:

Key	Symptom	Key	Symptom
————————	Numbness	ooooooooooo	Pins and Needles
xxxxxxxxxxxxxx	Burning Pain	//////////////////////////	Stabbing Pain
vvvvvvvvvvvvvv	Aching Pain		

Patient's Name: ____ Chart Number: __________________