



Patient History Questionnaire on Low Back Pain

Please fill in or mark the appropriate answers to both sides of this page:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

- 1. Where do you have pain? Back \_\_\_\_\_ Buttocks \_\_\_\_\_ Hip \_\_\_\_\_ Leg \_\_\_\_\_
2. What is your age? \_\_\_\_\_ Work Status? \_\_\_\_\_
Describe your normal activity level. \_\_\_\_\_
3. Have you previously had an x-ray or MRI for back pain? Yes \_\_\_\_\_ No \_\_\_\_\_
If yes when? \_\_\_\_\_
4. Have you had any history of injury or hospitalization? If yes, please list each with its date of occurrence.

- 5. Was the onset of your pain sudden? Yes \_\_\_\_\_ No \_\_\_\_\_
6. Do you have the following?
Muscle fatigue Yes \_\_\_\_\_ No \_\_\_\_\_
Difficulty sleeping because of muscle pain Yes \_\_\_\_\_ No \_\_\_\_\_
Morning stiffness Yes \_\_\_\_\_ No \_\_\_\_\_
Decreased motion in the spine Yes \_\_\_\_\_ No \_\_\_\_\_

- 7. What, if anything, have you done to manage your pain?
Ice \_\_\_\_\_ Heat \_\_\_\_\_ Cooling sprays \_\_\_\_\_ Topical preparation \_\_\_\_\_
Aspirin \_\_\_\_\_ Acetaminophen(eg. TYLENOL®) \_\_\_\_\_ Ibuprofen(eg.Motrin®) \_\_\_\_\_
Muscle relaxant \_\_\_\_\_ Antidepressant \_\_\_\_\_ Other medications \_\_\_\_\_
Physical therapy/training \_\_\_\_\_ Chiropractic manipulation \_\_\_\_\_

- 8. Have you had, or do you have, any of the following?
Cancer Yes \_\_\_\_\_ No \_\_\_\_\_
Unexplained weight loss Yes \_\_\_\_\_ No \_\_\_\_\_
Chills Yes \_\_\_\_\_ No \_\_\_\_\_
Recent infection Yes \_\_\_\_\_ No \_\_\_\_\_
Positive HIV test Yes \_\_\_\_\_ No \_\_\_\_\_
Fever Yes \_\_\_\_\_ No \_\_\_\_\_
Night pain Yes \_\_\_\_\_ No \_\_\_\_\_
Pain with rest Yes \_\_\_\_\_ No \_\_\_\_\_
Was the onset of your pain gradual? Yes \_\_\_\_\_ No \_\_\_\_\_
Bladder incontinence Yes \_\_\_\_\_ No \_\_\_\_\_
Urinary retention Yes \_\_\_\_\_ No \_\_\_\_\_
Bowel incontinence Yes \_\_\_\_\_ No \_\_\_\_\_

9. Have you had, or do you have, any of the following?
- |   |           |          |
|---|-----------|----------|
| Numbness in the buttocks                                      | Yes _____ | No _____ |
| Lower extremity weakness/numbness/tingling                    | Yes _____ | No _____ |
| Leg pain  | Yes _____ | No _____ |
| Pain radiating in lower leg while at rest?                    | Yes _____ | No _____ |
| In you answered yes to leg pain, which part of the leg? _____ |           |          |
| Increased pain while:   |           |          |
| Sitting?  | Yes _____ | No _____ |
| Driving?  | Yes _____ | No _____ |
| Waling?   | Yes _____ | No _____ |
| Coughing?   | Yes _____ | No _____ |

10. Mark below on the scale from 0 to 10 your level of pain and discomfort, with 0 being none and 10 being unbearable.
- None Unbearable
- 0 \_\_\_\_\_ 10

11. Mark below on the scale from 0 to 10 your level of disability due to your pain.
- None Unbearable
- 0 \_\_\_\_\_ 10

12. Mark the ares on your body where you feel the described sensations using the appropriate symbol. Mark areas of radiating pain, if any.

- |                |                                     |
|----------------|-------------------------------------|
| Numbness       | <input type="checkbox"/>            |
| Constant pain  | <input checked="" type="checkbox"/> |
| Dull ache      | ◆                                   |
| Stiffness      | ■                                   |
| Sharp twinge   | ▼                                   |
| Throbbing ache | +                                   |
| Burning        | ~                                   |

