LOW BACK PAIN QUESTIONNAIRE

This questionnaire is designed by your doctor to answer specific questions. Please answer each question as completely as possible.

Name: _____ Date: _____

1. How long have you had back pain? _____
2. When did pain become severe? _____
3. Do you know what started the pain you are suffering? ☐ Yes ☐ No
   If yes, describe what started your pain. _____
4. Did the pain begin after a work related injury? ☐ Yes ☐ No
   If yes, describe how you were injured: _____
   How did you feel immediately after the injury? _____
   Describe how you felt a few hours, the next day, and the next week after the injury: _____
   Describe how you felt a few hours, the next day, and the next week after the injury: _____

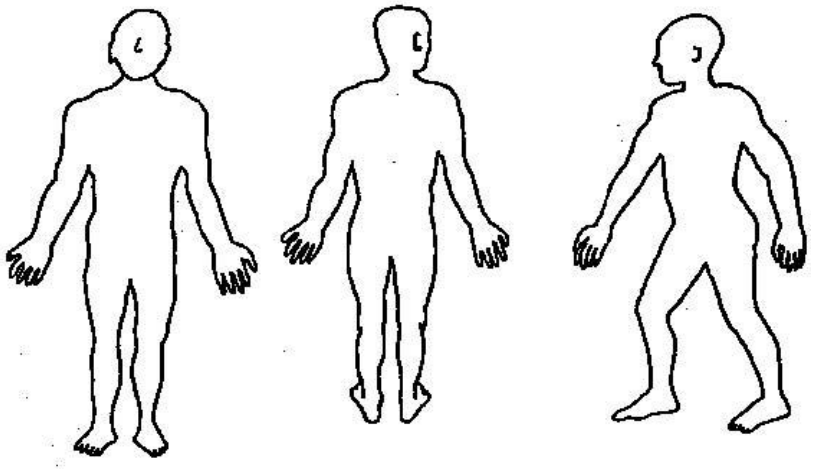
5. Describe the pain you experience. _____

_____

_____

_____

6. Use the figures to indicate where you experience pain.



7. Where is the worst pain? _____

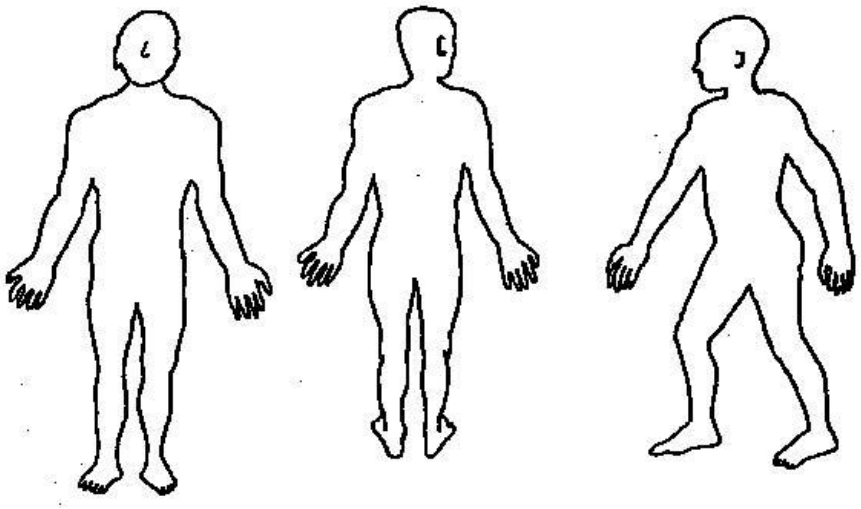
8. What makes the pain worse? _____

9. What makes the pain better? _____

10. Overall, do you think the pain is getting ☐ Better? ☐ Worse?

11. Do you experience numbness? ☐ Yes ☐ No

If yes, use the figures to indicate where the numbness occurs.



12. Have you noticed any weakness? ☐ Yes ☐ No

If yes, where do you feel weak? _____

13. Have you had any changes in your bowel or bladder habits recently? ☐ Yes ☐ No
If yes, please describe these changes. _____

14. Do you experience any pain when you cough or sneeze? ☐ Yes ☐ No
If yes where does the pain occur? _____

15. Have you noticed any clumsiness of the legs or feet lately? ☐ Yes ☐ No

16. What doctor(s) have you seen about your pain and what did they do for you?

17. Have you taken any medications for the pain? ☐ Yes ☐ No
If yes, please list the medications. Indicate who gave them to you and when. _____

Which medications helped you? _____

18. Please indicate which of the following treatments you have had and whether the treatment helped or not:

Bed rest	☐ Helped	☐ No Help
Physical Therapy	☐ Helped	☐ No Help
Traction	☐ Helped	☐ No Help
Chiropractor	☐ Helped	☐ No Help

19. Please list the x-rays you have had on your back?

TYPE OF X-RAY	DATE X-RAY TAKEN	DOCTOR

20. Have you ever had surgery on your back? ☐ Yes ☐ No
If yes, please indicate what was done, when, and by whom: _____