

Back Pain Questionnaire

Patient Name: _____
 Date of Birth: _____
 Today's Date: _____

How long have you had the pain in your back: _____

Did you have a fall or injury: Yes No
 If yes, how long ago: _____
 If yes, where did it occur: _____
 Any additional details: _____

On a scale of 1 → 10 with 10 being the worst pain you have ever had, rate your pain:

	None	-----								Severe
Your pain now:	1	2	3	4	5	6	7	8	9	10
Most of the time:	1	2	3	4	5	6	7	8	9	10

Does the pain radiate elsewhere: _____

Do you have any numbness, tingling or weakness in your arms: Yes No
 If yes, describe the location: _____

Do you have any numbness, tingling or weakness in your legs: Yes No
 If yes, describe the location: _____

What makes the pain worse: _____

What makes the pain better: _____

What medications have you taken for the pain: _____

Do you have osteoporosis: Yes No
 If yes, what do you take for osteoporosis: _____

Have you had any of the following? (Check all that apply)

- X-Ray CT Scan MRI Bone Scan Bone Density Testing

Have you ever had any surgeries or pain injections on your back: Yes No
 If yes, what did you have done: _____
 When was the procedure done: _____