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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: _____