



Michael Doherty, MD • Todd Durham, MD • Brian Fedeson, MD • Michael Knox, MD • Jarrod MacFarlane, DO • Jay Morrow, MD  
Bryan Mustert, MD • Chirag Patel, MD • William Rozell, DO • William Slater, MD • Jeff VanErp, MD • Manish Varma, MD

## 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: \_\_\_\_\_