Advanced Radiology Services PC

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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: _____