

BACK PAIN

Patient's Name _____ Date _____

Where is the pain located?

- Upper back**, what part of your upper back? _____
Does the upper back pain radiate to the chest wall? Yes No
- Middle Back**, what part of your middle back? _____
- Lower Back**, what part of your lower back? _____

What is the quality (description) of the pain?

- Aching Electric Shock type Numbing Other, describe: _____
 Burning Gnawing Stabbing _____

On a severity scale of 1-10 (1 being little pain at all and 10 being intolerable) my pain is a _____

Measure the severity of the pain regarding how it affects your daily activities:

- Mild – I am aware of it when present but it doesn't interfere with daily activities
 Moderate – when present it interferes only with some daily activities
 Severe – when present it interferes with most, but not all, daily activities
 Very severe – when present I am unable to carry out any daily activities
 Other description of severity _____

Are you experiencing the pain now? Yes No

How long have you had the pain? _____

Setting in which problem first occurred:

- Accident at home, briefly describe: _____
- Injury on the job
Date of accident: _____
Description of accident or injury: _____
Was it reported to workman's comp? Yes No
Are you off work due to the accident or injury? Yes No
- Motor vehicle accident
Circumstances of accident: _____
Mechanism of injury: _____

List any factors that aggravate the pain: _____

List any non-medical factors that relieve the pain: _____

Are you experiencing hip or leg pain? Yes No

Where is the hip or leg pain located?

- left/right hip left/right groin area left/right thigh left/right knee
 left/right lower leg left/right ankle left/right feet left/right toes

What is the quality (description) of the pain?

- Aching Burning Cold Sensation Hot Sensation Stabbing Weakness
 Gnawing Numbing Heavy Sensation Electric Shock Tingling Pins/Needles

Did the hip or leg pain begin before, during, or after the back pain? _____

Do you have: sleep disturbance bowel dysfunction bladder dysfunction

List any previous tests you have had for this problem? _____

How long have you had the pain? _____

List any previous treatments you have had: (home remedies, physical or occupational therapies, acupuncture or acupressure or massage therapy, etc) and their effectiveness:

List any medications you have tried for this problem and their effectiveness: _____