

Back Pain Questionnaire

Did your back pain start with a specific injury? Yes No
If yes: Date of injury: _____
Mechanism of injury: _____

If there was no injury did the pain start with a specific activity? Yes No
If yes: What activity/sport: _____
If there was no injury when did the pain start? _____

How would you describe the pain? (constant, intermittent, mild, moderate, severe, etc)

Where is the pain located? (upper, middle, lower back, left side, right side, etc.)

Do any of the following increase your pain?

Walking	Yes	Minimally	No
Standing	Yes	Minimally	No
Running	Yes	Minimally	No
Bending	Yes	Minimally	No
Stooping/squatting	Yes	Minimally	No
Sports	Yes	Minimally	No
Coughing/sneezing	Yes	Minimally	No
Is there anything else that increases the pain?	_____		

Do any of the following decrease your pain?

Rest	Yes	Minimally	No
Ice	Yes	Minimally	No
Heat	Yes	Minimally	No
Over the counter medications	Yes	Minimally	No
Prescription medications	Yes	Minimally	No
Is there anything else that decreases the pain?	_____		

Do you have any of the following symptoms?

Stiffness of your back	Yes	Minimally	No
Numbness or tingling in your leg(s)	Yes	Minimally	No
Weakness of your leg(s)	Yes	Minimally	No
Pain radiating into your leg(s)	Yes	Minimally	No
Night pain	Yes	Minimally	No
Unexplained fevers or chills	Yes		No
Unexplained weight loss	Yes		No
Bowel or bladder dysfunction	Yes		No

Do you have any other symptoms regarding your back pain? _____

Have you had any previous treatment for your back pain such as:

Physical therapy	Yes	No
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Chiropractic care	Yes	No
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Other treatment for back pain:	_____	
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In general do you feel that your back pain is getting better, getting worse, or staying about the same? _____

Have you had X-rays taken of your back?	Yes	No
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If yes:	Date of x-rays:	_____
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X-ray facility:	_____	
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Have you had an MRI scan of your back?	Yes	No
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If yes:	Date of the MRI:	_____
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MRI facility:	_____	
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Is there anything else that we need to know regarding our back pain? _____
