

LOWER BACK PAIN QUESTIONNAIRE

Circle answers where appropriate

1. Where is the pain? Please draw on the picture below.
2. How would you rate your pain on a scale of 0-10 with 0 being no pain today and 10 being the worst pain that you that you have ever experienced? _____
3. When did the pain start? _____
4. Did something seem to bring on the pain? _____

5. Have you had this type of pain or location of pain before? _____
When was the first time? _____
When was the last episode? _____
Have you had previous treatment? If so give specifics. _____
6. How would you describe your pain? Circle the appropriate response. SHARP DULL ACHY
BURNING SHOOTING NUMB TINGLING CONSTANT INTERMITTENT
OTHER: _____
7. Does your pain radiate to your legs/feet? _____ Which side? _____
8. Since the back pain began have you had any changes in your bowel or bladder functions?
If so how? _____
9. Has this pain kept you from working or doing things that you normally do? _____
Explain: _____
10. Have you seen another Doctor for this pain? _____
Have you had x-rays or other testing performed? _____
Are you taking medication? _____
11. What makes the pain better? _____
14. What makes the pain worse? _____
15. Have you had Chiropractic treatment for this or any other condition before? _____

Signature _____ Date _____

Please mark the area of pain on the figures below

