

**LOWER BACK PAIN INFORMATION**

**Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **MI** \_\_\_\_\_ **Date** \_\_\_\_\_

**Age** \_\_\_\_\_ **Birthdate** \_\_\_\_\_ **Gender** M F

**Occupation:** \_\_\_\_\_

What is your **Main Problem** ? (Check all that apply)

- Low Back Pain
- Buttock Pain
- Mid Back Pain
- Upper Back Pain
- Leg Pain
- Thigh Pain

**If you have Leg Pain** which is worse?

- I Don't have Leg Pain
- Both Legs hurt about Equally
- Both, Right Worse than Left
- Both, Left Worse than Right
- Right Leg Pain Only
- Left Leg Pain Only

How many weeks, days or months ago did this start? \_\_\_\_\_

**What Caused** This Problem?

- I Don't Know
- Car Accident
- A Fall
- Lifting
- Sports Injury
- Other: \_\_\_\_\_

Did it start **Gradually** or **Suddenly**?

- Gradually
- Suddenly

Have you seen any other Doctors For this? Yes No

If Yes write their names in order of #1 being the most recently seen.

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

**What Tests** Have You Had Done For This?

- X-rays
- Blood Tests
- MRI
- CAT Scan
- Myelogram
- Bone Scan
- Discogram
- EMG
- Nerve Root Block

**What Treatments** Have You Had For This?

- Nothing
- Rest
- Anti-Inflammatories
- Pain Medicines
- Muscle Relaxers
- Massage
- Chiropractic
- Physical Therapy
- Back Exercises
- Epidural Steroid Injection
- Prednisone
- Other: \_\_\_\_\_

**Do you get any regular Exercise?** Yes No

If Yes What Kind? \_\_\_\_\_

How many times a week? \_\_\_\_\_

**Current Symptoms**

Which of these **symptoms** do you have **now**?

- Back Pain
- Buttock Pain Rt. Lt.
- Leg Pain Rt. Lt.
- Numbness Where: \_\_\_\_\_
- Tingling Where: \_\_\_\_\_
- Leg Muscle Weakness
- Explain: \_\_\_\_\_
- Trouble Controlling Bowels or Bladder
- Pain with Coughing, Sneezing or Straining
- Pain that Wakes you from Sleep

Is Your **Back Pain** or **Leg Pain** Worse?

- Back Pain Worse than Leg Pain
- Leg Pain Worse Than Back Pain
- Back Pain about Equal to Leg Pain

**Is Your Back Pain:** Aching Burning Stabbing Sharp Dull Stiff Pins and Needles

Worse in the: Morning Evening Nighttime Mid Day

**Is Your Leg Pain:** Aching Burning Stabbing Sharp Dull Stiff Pins and Needles

Worse in the: Morning Evening Nighttime Mid Day

**What Makes Your Pain Worse?**

- Sitting
- Standing
- Walking
- Lying Down
- Exercise
- Lifting
- Bending Forward
- Bending Backward
- Working

**What Makes Your Pain Better?**

- Sitting
- Standing
- Walking
- Lying Down
- Exercise
- Pain Medicine
- Anti-Inflammatories
- Massage

**Do You Have Any of the Following Symptoms ?**

- Feeling Sick      Weight Loss      Fevers      Shaking Chills      Nausea
- Severe Morning Stiffness      Chronic Diarrhea

**How Far can you Walk Comfortably?**

- A few Steps Only
- Across The Street
- Less Than 2 Blocks
- Less Than A Mile
- More Than A Mile

**How Long Can You Stand Comfortably?**

- Less Than 5 Minutes
- Less Than 10 Minutes
- Less Than 20 Minutes
- Less Than 1 Hour
- More Than 1 Hour

**Sit Comfortably?**

- Less Than 5 Minutes
- Less Than 10 Minutes
- Less Than 20 Minutes
- Less Than 1 Hour
- More Than 1 Hour

**Are You Taking Any Medications For This Now?**

- |                 |               |
|-----------------|---------------|
| Medication Name | Pills Per Day |
| 1) _____        |               |
| 2) _____        |               |
| 3) _____        |               |
| 4) _____        |               |

**Recently are your symptoms?**

- Getting Worse
- Staying About the Same
- Getting Better

**Previous Back Problems**

Have You Had **Back Problems Before** This?    Yes    No                      If Yes How many years ago did it start? \_\_\_\_\_

Have You Had **Surgery on Your Back** Before?    Yes    No

If Yes Please List the Type of **Operation**, Approximate Year , and Doctor's Name

Operation	Year	Doctor
1) _____		
2) _____		
3) _____		
4) _____		

**Social History**

- How Far Did You Get In **School**?  
 Didn't Graduate High School      HS Grad  
 Some College      College Grad  
 Professional or Advanced Degree
- Are You **Married**?    Yes    No
- How Many **Children**?    1    2    3    4    5    6
- Are You **Working**?    Disabled    Retired    Working  
 Parenting    Taking Time Off    Unemployed

**Previous Medical Problems**

Please Check Any Medical Problems You Have Had or Currently Have

**Cardiac**

Hypertension  
Coronary Artery Disease  
Myocardial Infarction  
Congestive Heart Disease  
Atrial Fibrillation  
High Cholesterol

**Respiratory**

COPD  
Asthma

**Endocrine**

Diabetes  
Hypo- Thyroidism  
Hyper – Thyroidism

**GI**

Irritable Bowel Syndrome  
Colon Cancer  
Diverticulitis  
GE Reflux  
Hepatitis  
Ulcer Disease

**Urinary and Genital**

Enlarged Prostate  
Kidney Stone  
Urinary Tract Infection  
Prostate Cancer  
Bladder Cancer  
Renal Cancer  
Ovarian Cancer  
Uterine Cancer

**Musculoskeletal**

Degenerative Arthritis  
Of: \_\_\_\_\_  
Rheumatoid Arthritis  
Fibromyalgia  
Neck Pain  
Upper Back Pain

**Skin**

Melanoma  
Other Skin Cancer  
Psoriasis

**Neurologic**

Multiple Sclerosis  
Parkinson's  
Stroke  
Peripheral Neuropathy

**Psychiatric/ Emotional**

Alcoholism  
Drug Use / Abuse  
Depression  
Anxiety Disorder  
Bipolar Disorder

**Blood Disorders**

HIV  
Bleeding Disorder  
Anemia  
Leukemia  
Lymphoma

**Ear/Nose/ Throat**

Lip/ Tongue or Throat Cancer  
Chronic Sinusitis  
Hearing Problems

Enter Any Other Medical Problems Not Listed Above Here: \_\_\_\_\_

Please List Any Allergies to Medicines? \_\_\_\_\_

Please List All Regular Medications? \_\_\_\_\_

Do You **Smoke?** Yes No If Yes, How many packs per Day: \_\_\_\_\_

**Alcohol:** How Many **Drinks**, Glasses of Wine or Beers **per Day:** Never <1 1 2 3 4 5

Any Medical Problems That Run in The Family? \_\_\_\_\_

**Review Of Systems**

**Circle Any Symptoms you have now.**

<b>Cardiac</b>	Chest Pain	Leg Swelling	Irregular Heart Beats	Shortness of Breath Lying Down
<b>Respiratory</b>	Wheezing	Chronic Cough	Feeling Short of Breath Easily or at Rest	
<b>GI</b>	Heartburn	Blood In Stool	Black or Tarry Stools	Constipation
<b>Urologic</b>	Burning with Urination	Trouble With Urinary Stream	Blood in Urine	Frequent Urination
<b>Musculoskeletal</b>	Joint Pain or Swelling	Lower Back Pain	Severe Morning Stiffness	
<b>Endocrine</b>	Excessive Thirst	Weight Gain	Excessive Fatigue	Excessive Urination
<b>Hematologic</b>	Bleeding Problems	Easy Bruising		
<b>Psychologic</b>	Crying Frequently	Feeling Worthless	Lack of Libido	Trouble Sleeping
<b>ENT</b>	Eye Pain	Wear Corrective Lenses	Trouble Hearing	Sinus Congestion
<b>Gynecologic</b>	Pelvic Pain	Symptoms of pregnancy	Uterine Bleeding	Vaginal Discharge

Any other symptoms you would like to mention? \_\_\_\_\_

PATIENT PAIN DRAWING

Where is your pain now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.  
 Mark the areas of radiation. Include all affected areas. To complete the picture please draw in your face.

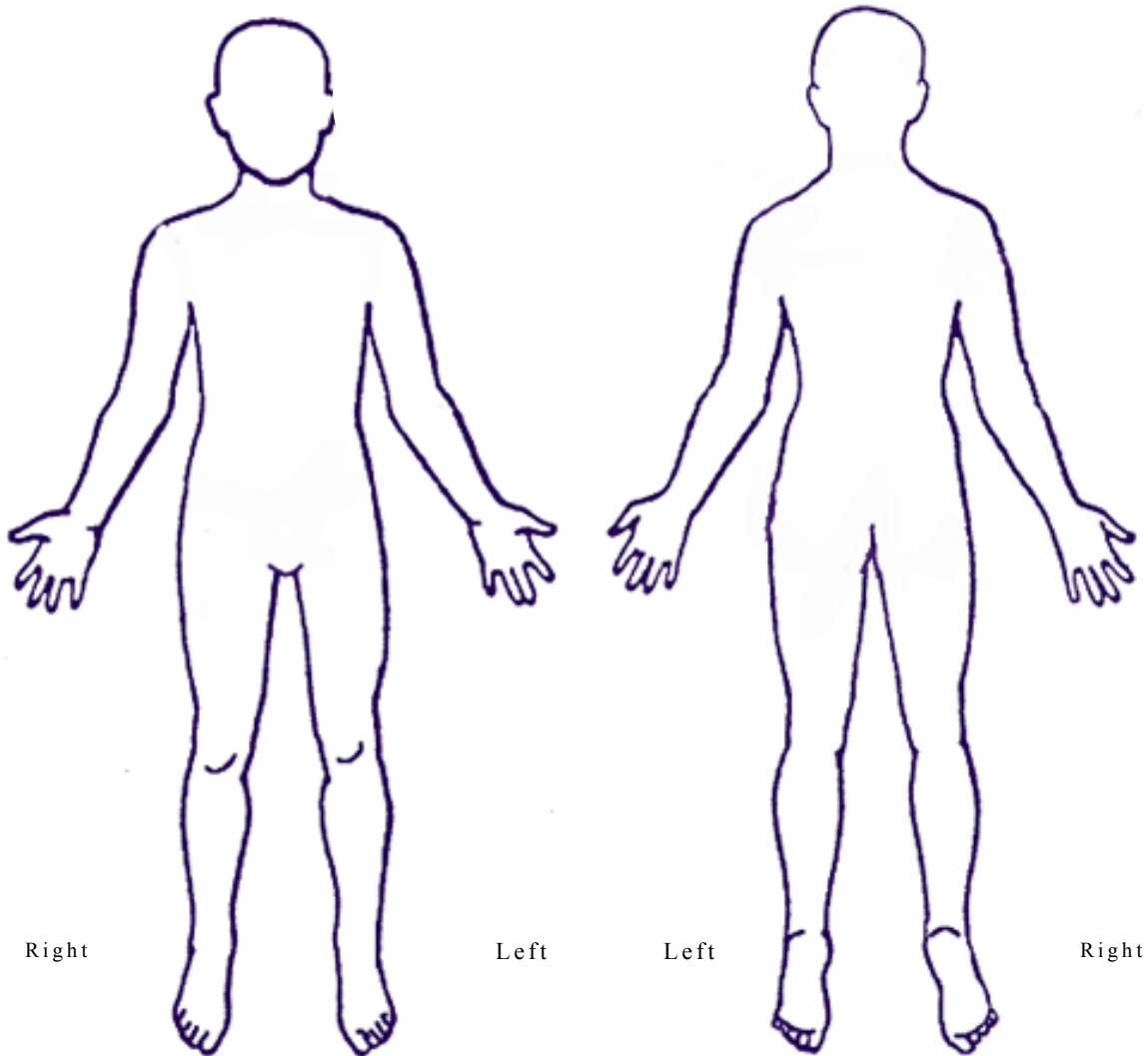
Aching  
 ▲▲▲

Numbness  
 = = =

Pins and needles  
 ○ ○ ○

Burning  
 X X X

Stabbing  
 / / /



How bad is your pain now?

Please mark and + on the body form where the pain is worst now

Please Mark on the line below how bad your pain is now

No Pain \_\_\_\_\_ Worst possible pain