PATIENT QUESTIONAIRE - DISORDERS OF THE LOW BACK

Patient Name: _____ Age: ___ Referred by:_____

What is the primary complaint that brought you here today? (Describe events)

When did your symptoms begin?

Was there an accident or injury prior to these symptoms? **NO YES** If, yes, when was the accident?
Is the accident work related? **NO YES** Is there litigation pending or a possibility of litigation? **NO YES**
Please describe the accident (If a MVA, were you wearing a seatbelt?) Did you have a shoulder strap on?

Have you ever 1) Experienced back or leg pain prior to this episode? **NO YES** 2) Seen a doctor for back or leg pain? **NO YES** 3)Had any treatment on your spine for back and leg pain? **NO YES**

Do you have low back pain? Describe

Do you have leg pain? R L B Describe.

Which is worse BACK or LEG ?

Have you noticed any numbness or weakness? Where? Describe

What aggravates the pain?

Does coughing or sneezing aggravate the pain?

What improves your pain?

Are your symptoms worst at night? **NO YES**

Have you had a change in bowel movements or bladder habits after the pain started? Loss of control?
What treatment have you received? Describe response.

Chiropractic	Bed Rest
Physical Therapy	Epidural Injections
NSAIDS	

Are your symptoms improving, getting worse or staying the same? Are you able to live with the pain?

Are you currently on a low back exercise program? **NO YES**
What testing have you had for this problem? (Please note date. Are all the films here with reports or are we obtaining them?)

MRI	CT	Myelogram	EMG/Nerve Conduction
Plain films / xrays	Discogram	SNRI	Other