BACK QUESTIONNAIRE

TODAY'S DATE ____________________

NAME ____ DATE OF BIRTH ____________________

TYPE OF WORK ____

WHAT TYPE OF INJURY? ____

When did back or neck pain originally start? ____

When did arm or leg pain originally start? ____

When did your current episode begin? ____

Did your pain start . . . . gradually? _______ suddenly? _______ injury? _______

Have you had any testing? _______ X-Ray _______ CT _______ MRI _______ EMG Where? ____________

What medications have you tried? ____
(ie: pain medication, Motrin, Aleve, Ibuprofen, etc.)

My pain is: (please check appropriate answer)	Better	Worse	Same
With cough or sneeze	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Bending forward	☐	☐	☐
Bending backward	☐	☐	☐
Lying on back	☐	☐	☐
Lying on side	☐	☐	☐
Lying on stomach	☐	☐	☐

What time of day is your pain worse?:

Morning _______ Later in the day _______ Middle of the night _______

Do you have numbness or tingling in arm or leg? ________________ Please describe: ____________________

____

Have you had physical therapy? ____________________ Chiropractic therapy? ____________________

If yes, please provide dates ____________________ By whom? ____________________

Are there any changes in bowel or bladder habits?

Please describe ____

____

Do you feel stiffness in the morning? ____

Please mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas. Just to complete the picture, please draw your face.

Numbness	– – – – –	Pins and Needles	o o o o	Burning	x x x x	Stabbing	I I I I
	– – – – –		o o o o		x x x x		I I I I
	– – – – –		o o o o		x x x x		I I I I