

LOW BACK ASSESSMENT

1. When did your back pain first begin? _____
 2. How did the pain very first start? _____
 3. Did the pain first begin – (check one)
 Suddenly
 Slowly with gradual progression
 4. What started or brought on the pain this time? _____
 5. How did the pain begin this time – (check one)
 Suddenly
 Slowly with gradual progression
 6. Describe your pain:(aching, stabbing, throbbing, burning, ect.) _____
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7. Frequency of low back pain: (check one)
 Constant
 Daily
 Intermittent
 Night only
 8. How long does it last? (check)
 All day
 Few hours
 Minutes
 9. Does pain radiate into your leg(s)? (check one)
 yes-right leg
 yes-left leg
 yes-both legs
 no (if no proceed to question #14)
 10. Describe the specific location of your leg pain? _____
 11. Describe your leg pain: (aching, stabbing, pins/needles, burning, ect.) _____
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12. Frequency of leg pain: (check one)
 Constant
 Daily
 Intermittent
 Night only
 13. Do you have weakness in your leg(s)? yes no

Patient Name: _____

Date: _____

14. What makes the pain worse? (check all that apply)

- | | | |
|---------------------------------------------|---------------------------------------------|-----------------------------------|
| <input type="checkbox"/> bending | <input type="checkbox"/> lifting | <input type="checkbox"/> twisting |
| <input type="checkbox"/> prolonged standing | <input type="checkbox"/> prolonged sitting | <input type="checkbox"/> walking |
| <input type="checkbox"/> coughing/sneezing | <input type="checkbox"/> getting in/out car | |

15. What makes the pain better? (check all that apply)

- | | | |
|---------------------------------------------|----------------------------------------|-----------------------------------|
| <input type="checkbox"/> rest | <input type="checkbox"/> heat | <input type="checkbox"/> ice |
| <input type="checkbox"/> lying flat on back | <input type="checkbox"/> lying on side | <input type="checkbox"/> medicine |
| <input type="checkbox"/> nothing | <input type="checkbox"/> other | |

16. Is the pain usually worse (check one)

- as the day progresses
 in the morning when you first get up
 at night in bed

17. List medications you are taking for the pain: (include over-the-counter drugs) _____

18. Does medication help? _____

19. List any and all surgeries with approx. dates? _____

20. Do you have trouble sleeping? yes no

21. Type of bed you sleep on? water standard
How old is mattress? _____

22. Do you do physical work? (this includes work at home) yes no

Please describe _____
