Name:

Low Back Pain Questionnaire

When did your pain start?----------

How did your pain start? Ie gradual, sudden, accident----------

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If this was due to a car accident, is ICBC involved or do you have a legal case pending?----------

Can you describe your pain ie aching/burning ----------

Where is your pain located? Is your pain located more to one side? Does it radiate anywhere?

Has your pain been getting better/worse/staying the same?----------

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What makes your pain better? Stretching, rest, exercise, standing, medications? (Please circle)

Anything else that makes it better?:_____

What makes your pain worse? Bending, twisting, work, exercise (Please circle) Any others?:

On a scale of 0-10 with 0 being no pain, and 10 being the worst pain you could imagine,

How do you rate your pain on your best day---------- your worst day----------

In the last 24 hours, how much relief have your pain treatments or medications provided? Please circle the one percentage that shows most how much **RELIEF** you have received.

No relief 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Complete relief

Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

Name:

1. **General Activity:**

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

2. **Mood:**

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

3. **Walking Ability:**

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

4. **Normal Work (includes both work outside the home and housework)**

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

5. **Relations with other people:**

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

6. **Sleep:**

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

7. **Enjoyment of Life:**

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

Review of Symptoms. Please circle if you have been experiencing any of the following:

Numbness or tingling in your legs	Fever	Weight loss
Change in bowel or bladder function	Night Pain	Chills
Loss of balance or Coordination	Dizziness	Loss of Hearing
Loss or Change in Vision	Changes in Speech or Swallowing	

Any others?:_____

Have you tried any of the following treatments? If so, were they successful?

Physiotherapy----------

Chiropractor----------

Injections----------

Name:

Medications----------

Surgery----------

Have you had any investigations for this problem? ie CT, x-ray, MRI. Where and when?----------

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Please tell me about any medical conditions you have----------

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Please list any surgeries you have had in the past----------

Please list any drug allergies----------

What do you do/did you do for work?----------

Do you do a regular exercise program? If so, what type of exercise and how frequently?----------

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Please list your current medications _____

_____

_____

Are you a smoker Yes or No? Do you have a past history of smoking?----------

How much alcohol would you drink in a week?----------

Do you use street drugs, or have you ever had problems with addiction issues?----------

What are your hopes for today's visit?----------

Please circle the area (s) that you have pain.