Lower Back Pain Questionnaire

Name:_____ Date:_____

1. My back hurts: O more on the right O more on the left O both sides equally
2. My leg hurts: O more on the right O more on the left O both sides equally
3. O My back hurts more than my leg(s).
O My leg(s) hurt more than my back.
O They hurt equally.

4. I have weakness in: O right leg O left leg O both legs.
5. I have numbness in: O right leg O left leg O both legs. Where? ____
6. I have bladder control problems. O no O yes
7. I have bowel control problems. O no O yes
8. I have balance problems. O no O yes
9. I have *(check all that apply)*: O fevers O chills O weight loss
O weight gain O problems sleeping

10. The following make my pain:	**worse**	**better**	**no change**
bending	**O**	**O**	**O**
sitting	**O**	**O**	**O**
coughing/sneezing	**O**	**O**	**O**
driving	**O**	**O**	**O**
lifting	**O**	**O**	**O**
standing	**O**	**O**	**O**
walking	**O**	**O**	**O**
laying down	**O**	**O**	**O**
laying on right side	**O**	**O**	**O**
laying on left side	**O**	**O**	**O**
other_____	**O**	**O**	**O**

11. Check treatments used.	**USED**	**HELPED**
Physical Therapy	**O yes O no**	**O yes O no**
Chiropractic	**O yes O no**	**O yes O no**
Massage	**O yes O no**	**O yes O no**
Acupuncture	**O yes O no**	**O yes O no**
Steroid pack	**O yes O no**	**O yes O no**
Epidural injections	**O yes O no**	**O yes O no**
Surgery	**O yes O no**	**O yes O no**
Other _____	**O yes O no**	**O yes O no**