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# BACK PAIN ASSESSMENT

## PERSONAL INFORMATION:

NAME:____________________________________
BIRTH DATE:________________
AGE: ______ MALE_____ FEMALE_________
MARITAL STATUS: ___Married ______Divorced
____Single_____Separated

**DATE FILLING OUT:**___________________________
**BACK SYMPTOMS:**
**Where is your pain and for how long?**

| LOCATION | DURATION |
|---|---|
| NECK | __________ |
| MID BACK | __________ |
| LOW BACK | _________ |
| BUTTOCK OR HIP | _________ |
| DOWN THE LEG | _________ |
| OTHER | __________ |

______________________________
______________________________

**Was the onset of your present pain?**
__SUDDEN (MIN.) __ SUDDEN(HRS)
__GRADUAL (DAYS) __ GRADUAL(WEEKS)
__OTHER; __ UNKNOWN
_______________________________________

**What was the cause of your pain?**
__UNKNOWN __HIT IN THE BACK
__LIFTING __AUTO ACCIDENT
__TWISTING __BENDING
__FALL __PULLING

**Do you believe your pain is related to a work injury?**
__NO __POSSIBLE
__YES; DATE INJURED:_____________

**When having pain is it generally....**
__MILD DISCOMFORT OR LESS
__DULL PAIN, WORSE AT TIMES
__HARD ACHING PAIN, FREQUENTLY WORSE
__SEVERE PAIN, SHARP/ SHOOTING AT TIMES
__VERY SEVERE, SHARP, SHOOTING, DISABLING
__SEVERE & DISABLING

**How often are you having pain now?**
__ RARELY IF EVER
__ OCCASIONAL (1-2 EPISODES PER YEAR)
__ RECURRENT ( 2-3 DAYS EVERY FEW MONTHS)
__ FREQUENT (>3 DAYS PER MONTH)
__ VERY FREQUENT ( EVERY WEEK)

**Describe your pain as;**
**(C) CONSTANT (D)DULL**
**(I) INTERMITTENT (T) THROBBING**
**(S) SHARP (B) BURNING**

___NECK ___BUTTOCK/HIP
___MID BACK ___ DOWN LEG
___LOW BACK ___ OTHER
__________________________________________________
__________________________________________________

**What time of day is your pain usually worse?**
__MORNING __ SAME ALL DAY
__ MID-DAY __ AT NIGHT IN BED
__ EVENING

**What makes your pain worse?**
__ LYING DOWN __ BENDING FORWARD
__ SITTING __ BENDING BACK
__ STANDING __ COUGHING
__ WALKING __ SNEEZING
__ LIFTING __ SLEEPING
__ TWISTING __ OTHER
__________________________________________________
__________________________________________________

**What makes your pain better?**
__ LYING DOWN __ BENDING FORWARD
__ SITTING __ BENDING BACK
__ STANDING __ MEDICATION
__ WALKING __ PHYSICAL THERAPY
__ NOTHING __ OTHER
__________________________________________________
__________________________________________________

**Since the onset, is your pain getting...**
__ RAPIDLY WORSE __ RAPIDLY BETTER
__ SLOWLY WORSE __ SLOWLY BETTER
__ UNCHANGED

**Since the onset of this episode of pain, have you had any...**
__NUMBNESS IN THE FOOT;LEFT, RIGHT, OR BOTH
__ NUMBNESS IN LEG; LEFT, RIGHT, OR BOTH
__ BLADDER PROBLEMS
__ BOWEL PROBLEMS
__ PAIN THAT WAKES YOU FROM SLEEP
__ FEVER, CHILLS, SHAKES, SWEATS
PLEASE DESCRIBE, INCLUDE DETAILS AND DATES.
__________________________________________________
__________________________________________________
__________________________________________________

**Prior to the onset of this episode of pain, had you noticed any...**
__ NUMBNESS IN FOOT; LEFT,RIGHT, OR BOTH
__ NUMBNESS IN LEG; LEFT, RIGHT, OR BOTH
__ BLADDER PROBLEMS
__ BOWEL PROBLEMS
__ PAIN THAT WAKES YOU FROM SLEEP
__ FEVER, CHILLS, SHAKES,SWEATS
PLEASE DESCRIBE, INCLUDE DETAILS AND DATES.
______________________________________________
______________________________________________
______________________________________________
______________________________________________

## WORK AND RECREATIONAL ACTIVITIES

**Are you presently employed?**
__ NO; HOW LONG SINCE YOU WERE?
______________________________________________

__YES; WHERE AND FOR HOW LONG?
______________________________________________
______________________________________________

WHAT IS YOUR OCCUPATION?

______________________________________________
(**PRESENT)**
______________________________________________
**(PREVIOUS OCCUPATIONS)**
______________________________________________

**Activities at home or work mostly involve;**
__ MANUAL LABOR, HEAVY LIFTING
__ MANUAL LABOR, LESS STRENUOUS
__ SITTING MOST OF THE DAY
__ WALKING OR STANDING MOST OF THE DAY
__ HOUSE WORK AND CHILD CARE
(#_____CHILDREN)

**How is the pain limiting your job and/or home activities?**
__ NOT LIMITED IN ANY WAY
__ NOT LIMITED MUCH DUE TO PAIN
__ ABLE TO WORK AROUND THE PAIN
__ MUST STOP AND LIMIT ACTIVITIES
__ UNABLE TO WORK FOR DAYS AT A TIME
__ UNABLE TO WORK AT ALL DUE TO PAIN

**Has your present episode of pain prevented you from working your regular job?**
__ NO
__ NOT APPLICABLE
__ YES; HOW MANY WORK DAYS MISSED?
______________________________________________

**What activities have you enjoyed in the past that pain prevents you from enjoying today?**
______________________________________________
______________________________________________

**How much is your pain limiting your social, recreational, and other activities?**
__ NOT LIMITED IN ANY WAY
__ NOT LIMITED MUCH DUE TO PAIN
__ ABLE TO DO MOST THINGS WITH THE PAIN
__ MODIFY ACTIVITIES TO CONTROL THE PAIN
__ GREATLY LIMIT ACTIVITIES TO CONTROL PAIN
__ UNABLE TO PARTICIPATE IN ANY ACTIVITIES

## EVALUATION & TREATMENT

**What other medical/osteopathic doctors, Chiropractors have you seen for your problems?**
(List names and dates)

**Doctors:**__________________________________
______________________________________________
______________________________________________
______________________________________________

**Chiropractors:**______________________________
______________________________________________
______________________________________________
______________________________________________

**What studies have been done?**
(List where and when)
__ NONE
XRAY;________________________________________
CT SCAN;_____________________________________
MYELOGRAM;__________________________________
MRI SCAN;____________________________________
BONE SCAN;__________________________________
EMG;________________________________________

**What treatment have you received?**
(List by whom and when)
__NONE
MANIPULATIONS;______________________________
BRACE/CORSET;_______________________________
PHYSICAL THERAPY;___________________________
SPINALBLOCK;________________________________
HOSPITALIZED;_______________________________
OTHER;______________________________________

**Do you take any medication for your pain?**
__NO
__ YES; LIST MEDICATIONS AND DOSAGES
______________________________________________
______________________________________________

**Have you had back surgery?**
__ NO
__ YES; LIST TYPE, DATE AND SURGEON.
DID IT HELP YOUR PAIN?_____________________
______________________________________________
______________________________________________
______________________________________________

## PAST MEDICAL HISTORY:

**Please rate your general health.**
__ EXCELLENT __ FAIR
__ GOOD __ POOR

**Do you have any medical problems for which you regularly see a doctor?**
__ NO
__ YES; LIST DOCTOR AND PROBLEM:
______________________________________________
______________________________________________
______________________________________________

**Have you had surgery?**
(OTHER THAN BACK SURGERY)
__ NO
__ YES; LIST TYPE, DATE, AND SURGEON:
______________________________________________
______________________________________________
______________________________________________

**Have you ever been seriously injured?**
__ NO
__ YES; DETAILS AND DATES:
______________________________________________
______________________________________________
______________________________________________

**Have you ever been hospitalized?**
__ NO
__ YES; WHEN AND WHERE:
______________________________________________
______________________________________________
______________________________________________

**Do you have any allergies to medications?**
__ NO
__ YES; LIST DRUG(S) AND REACTION(S):
______________________________________________
______________________________________________
______________________________________________

**Please list your current medications and dosages.**
______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

**Have you ever been evaluated/treated for substance (drugs/alcohol)dependence?**
__NO
__ YES; WHEN, WHERE, AND BY WHOM?
______________________________________________
______________________________________________
______________________________________________

**Have you ever been treated for emotional/psychiatric problems?**
__ NO
__ YES; WHEN, WHERE,A ND BY WHOM?
______________________________________________
______________________________________________

**Did you suffer any unusal childhood illness?**
__NO
__ YES; WHAT AND WHEN?
______________________________________________
______________________________________________

## FAMILY HISTORY:

**Are there any medical problems that tend to run in your family?**
__ NO
__ YES; LIST FAMILY MEMBER AND CONDITION:
______________________________________________
______________________________________________

**Do back problems tend to run in your family?**
__ NO
__ YES; LIST FAMILY MEMBER AND CONDITION:
______________________________________________
______________________________________________

ANY BACK SURGERY? __NO __ YES

## SOCIAL HISTORY:

**What is the highest level of education you have completed?**
__ GRADE SCHOOL __ COLLEGE
__ HIGH SCHOOL __ GRADUATE SCHOOL
__ TRADE SCHOOL

**Do you like you work?**
__ YES
__ NOT APPLICABLE
__ NO; WHY NOT?
______________________________________________
______________________________________________

**Do you like your boss/supervisor?**
__ NO
__ NOT APPLICABLE
__ YES

**In the past have you been unable to work because of pain?**
__NO
__ NOT APPLICABLE
__ YES;HOW MANY DAYS TOTAL
______________________________________________

**Have you had past work related back injuries?**
__NO
__ YES; LIST HOW AND WHEN______________________
______________________________________________
______________________________________________

**Do you exercise on a regular basis?**
__ NO
__ YES; DOING WHAT, HOW MANY DAYS/WEEK?
______________________________________________
______________________________________________

**Do you smoke or chew tobacco?**
__ NO
__ YES; HOW MUCH?
______________________________________________

**Do you drink alcohol ( beer, wine, liqueur)?**
__ NO
__ YES; HOW OFTEN /MUCH

**Have any of the following reasons caused you to be emotionally upset recently?**
__ NOT UPSET __ MARITAL __SOCIAL
__ WORK __ LEGAL __ FINANCIAL
__OTHER_______________________________________
______________________________________________

**If your condition does not improve, what will your future plans include?**
______________________________________________
______________________________________________
______________________________________________

**Do your religious beliefs prevent you from receiving blood transfusion if medically necessary?**
__ NO
__ YES

## MEDICAL LEGAL INFORMATION:

**Have you ever been involved in a medical law suit?**
__ NO
__ YES; PLEASE EXPLAIN
______________________________________________
______________________________________________

**Are you involved in a medical lawsuit now?**
__NO
__ YES; PLEASE EXPLAIN.
______________________________________________
______________________________________________

**Is an attorney currently involved with your back problem?**
__ NO
__ YES; PLEASE EXPLAIN
______________________________________________
______________________________________________

## REVIEW OF SYSTEMS:

**PLEASE INDICATE IF YOU NOW HAVE (OR HAVE HAD IN THE PAST)PROBLEMS WITH ANY OF THE FOLLOWING;**

__ WEIGHT LOSS
__ WEIGHT GAIN
__ FEVER, CHILLS, SWEATS
__ POOR CIRCULATION
__ DEPRESSION
__ VISION
__ SEVERE INDIGESTION
__ NOSE BLEEDS
__ DENTURES/CAPS
__ LOOSE TEETH
__ CHIPPED TEETH
__ JAW PAIN
__ NECK PAIN
__ ASTHMA
__ EMPHYSEMA
__ BRONCHITIS/PNEUMONIA
__ CHEST PAIN
__ HEART ATTACK/HEART FAILURE
__ HEART MUMMUR
__ ARRYTHMIA
__ HIGH BLOOD PRESSURE
__ HEADACHES
__ STROKE
__ BLOOD TRANSFUSION

__DIABETES
__ THYROID DISEASE
__ SLEEP
__ MUSCLE CRAMPS
__ HIATAL HERNIA
__ STOMACH ULCER
__ LIVER DISEASE
__ HEPATITIS
__ GALL BLADDER
__ PANCREATITIS
__ BOWEL DISEASE
_DRK/BLOODY STOOL
__ PELVIC PAIN
__ KIDNEY STONES
__ BLADDER
INFECTIONS
__ HISTORY CANCER
__ ARTHRITIS/GOUT
__ SEIZURES/FITS
__ WOUND
INFECTIONS
__ ANESTHESIA
__ AIDS/HIV

Please indicate by a mark on the bar below, how much pain you are presently getting from your back on average.

0 10

◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊ ◊

NO PAIN WORST PAIN

**At present, are you working ?**
**(House wives and retired persons relate activity to previous abilities)**

__FULL TIME AT USUAL JOB
__ FULL TIME AT A LIGHTER JOB
__ PART TIME
__ NOT WORKING

**At present, can you undertake household chores or odd jobs?**

__ NORMALLY
__ AS MUCH AS USUAL BUT SLOWLY
__ A FEW, NOT AS MANY AS USUAL
__ NOT AT ALL

**At present, can you undertake sporting or social pursuits? (e.g. dancing)**

__ AS MUCH AS USUAL
__ ALMOST AS MUCH AS USUAL
__ SOME, MUCH LESS THAN USUAL
__ NOT AT ALL

**How often have you seen a doctor or had treatment (e.g. physical therapy) for your pain?**

__ NEVER
__ RARELY
__ ABOUT ONCE A MONTH
__ MORE THAN ONCE A MONTH

**How often do you take pain killers for pain?**

__ NEVER
__ OCCASIONALLY
__ ALMOST EVERY DAY
__ SEVERAL TIMES EACH DAY

**Do you have to rest during the day because of pain?**

__ NO
__ A LITTLE
__ HALF THE DAY
__ OVER HALF THE DAY

**Does your pain regularly disturb...**

SOCIAL ACTIVITIES __NO __YES
SEXUAL ACTIVITY __NO __YES
SLEEP __NO __YES

**Activity level on average is best described as;**

__ BEDRIDDEN
__ WHEELCHAIR BOUND
__ HOUSE BOUND
__ LIGHT PHYSICAL ACTIVITY
__ LIGHT WORK
__ LIMITED MEDIUM WORK
__ MEDIUM WORK
__ HEAVY WORK WITH PAIN
__ NO LIMITATION

**Please mark any activities that you can do;**

__ LIFT A SMALL (3 YEAR OLD) CHILD
__ SIT FOR HALF AN HOUR
__ STAND IN ONE PLACE FOR HALF AN HOUR
__ TRAVEL IN A CAR OR BUS FOR HALF AN HOUR
__ WALK 500 YARDS
__ PUT SHOES AND SOCKS ON WITHOUT HELP
__ GENERAL HOME MAINTENANCE
__ (i.e. VACUUM, WASH DISHES, LAUNDRY)

**How does pain effect the following activities?**

| | **severely impossible** | **moderately difficult** | **mildly not much** | **not at all** |
|---|---|---|---|---|
| SLEEPING | ◊ | ◊ | ◊ | ◊ |
| WALKING | ◊ | ◊ | ◊ | ◊ |
| SITTING | ◊ | ◊ | ◊ | ◊ |
| DRIVING | ◊ | ◊ | ◊ | ◊ |
| DRESSING | ◊ | ◊ | ◊ | ◊ |
| SEX LIFE | ◊ | ◊ | ◊ | ◊ |
| WORK | ◊ | ◊ | ◊ | ◊ |
| SPORTS | ◊ | ◊ | ◊ | ◊ |
| EXERCISE | ◊ | ◊ | ◊ | ◊ |

## PAIN SCALE:

*** How much of your total pain is from your back, and how much is from your buttock,hip, or leg?**

100% **TOTAL** PAIN=____________% BACK PAIN + ___________% BUTTOCK ,HIP, OR LEG PAIN.

*** Please rate your pain when it is <u>LEAST</u> bothersome by placing a single mark on scale below.**
**( 0 = NO PAIN ) ( 10= WORST PAIN IMAGINABLE)**

**0 1 2 3 4 5 6 7 8 9 10**

***Please rate your pain when it is <u>MOST</u> bothersome by placing a single mark on the scale below**

**0 1 2 3 4 5 6 7 8 9 10**

**PAIN DRAWING :**
On the figures below please indicate where you are having any:
***Draw arrows to show where pain goes or shoots**
***Please indicate where the pain is worse**
***Be sure to show ALL areas involved**

**ACHING/PAIN (XXXX)**
**NUMBNESS/TINGLING (0000)**
**PINS/NEEDLES (.........)**
**BURNING (////)**
**SPASM/CRAMP (∇∇∇∇)**