

# LOWER BACK COMPLAINTS

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Are your current complaints related to an auto accident? No / Yes. If Yes Date: \_\_\_\_\_

Are your current complaints related to a work-related injury? No / Yes. If Yes Date: \_\_\_\_\_

## **SELECT ALL ANSWERS BASED ON LOWER BACK ONLY**

Does your pain radiate? No / Yes. If Yes, please indicate where: \_\_\_\_\_

### **QUALITY:** Circle ALL that apply to the above complaint)

Aching	Heavy	Spasm	Throbbing
Burning	Loss of motion	Sharp	Tightness
Cramping	Numbness	Shooting	Weakness
Deep	Painful to Touch	Stabbing	Localized Pain
Vague-Constant	Piercing	Stiffness	
Dull	Radiating	Tenderness	

### **Pain Rating Scale**

Rate your current pain on a scale of 1-10.  
0 indicates no pain and 10 indicates extreme pain.

Your Rating is: \_\_\_\_\_

### **SEVERITY:**

(CIRCLE ONLY ONE) Mild / Moderate / Severe

(CIRCLE ONLY ONE) Getting Worse / Improving / Staying the Same

(CIRCLE ONLY ONE) Occasional / Intermittent / Frequent / Constant

### **DURATION:**

WHEN DID THE SYMPTOMS FIRST APPEAR: \_\_\_\_\_ (exact date and year are required)

### **TIMING:** (circle all that apply)

What **IMPROVES** the pain

- Bending or Stooping
- Exercise
- Getting Off Feet
- Heat
- Hot Shower
- Laying Down
- Massage
- Manipulation of Spine
- Movement
- OTC Meds
- Physical Activity
- Rest
- Sitting
- Standing
- Stretching
- Support / Brace
- Walking
- Other: \_\_\_\_\_

### **TIMING:** (circle all that apply)

What **WORSENS** the pain:

- Bending or Stooping
- Computer Use
- Coughing / Sneezing
- Driving
- Exercise
- Joint Use
- Laying Lifting
- Movement
- On Extreme Motion
- On Feet
- Physical Activity
- Pressure of any type
- Resting
- Sitting
- Sleeping
- Standing
- Straining
- Twisting
- Walking
- Walking UP / Down Stairs
- Weight Bearing
- Other: \_\_\_\_\_

Ht: \_\_\_\_\_ inches Weight: \_\_\_\_\_ lbs

Right or Left Handed (circle one)

Is the pain worse in the: (circle all that apply)

- Morning Time
- End of Day
- Night Time
- Various Times

### **CONTEXT:**

What does your condition interfere with: (circle all)

- Daily Living Activities
- Normal Lifestyle
- Sleep
- Work Activities
- Leisure Activities
- Exercise / Working Out / Gym
- Housework
- Outside Work / Gardening
- Other: \_\_\_\_\_