

# Lower Back Pain Questionnaire

Please Only Fill This Form Out If YOU Are Experiencing This Pain!

If You Do Not Have This Pain Then Skip This Form!

1. Where in your lower back are you feeling pain?

Front                      Back                      Left Side                      Right Side

2. How would you rate the level of your pain you feel right now on a scale of 1 to 10? **One is no pain, ten is severe pain.**

1   2   3   4   5   6   7   8   9   10

3. When the pain is at its worst what number would you rate it? **One is no pain, ten is severe pain.**

1   2   3   4   5   6   7   8   9   10

4. When the pain is at its best what number would you rate it?

**One is no pain, ten is severe pain.**

1   2   3   4   5   6   7   8   9   10

5. What is the frequency of pain? How often do you feel the pain?

0-25%                      25-50%                      50-75%                      75-100%

6. Does your pain refer to any of the following areas?

Hips

Buttocks

Front of legs

Back of legs

Left-Right or Both

Left-Right or Both

Left-Right or Both

Left-Right or Both

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

7. What relieves your pain?

Rest   Ice   Heat   Stretching   Medicine type: \_\_\_\_\_

8. When you do get relief what percentage does your pain improve?

0-25%      25-50%      50-75%      75-100%

9. How would you describe the pain?

Sharp   Dull   Achy   Stiff   Tight   Burning   Numb

10. When is the pain at its worst?

Morning      Afternoon      Evening      All Day

11. What caused this pain? What were you doing when you first felt the pain?

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