LOW BACK/ HIP PAIN QUESTIONNAIRE

Patient Name: _____ **Date:** _____

How long have you had low back / hip pain?

Is your low back / hip pain rapidly getting worse? Yes / No

Is your low back / hip pain secondary to major trauma (car accident, fall from height)? Yes / No
If yes, describe in detail:

If from car accident, fill out *Motor Vehicle Accident Questionnaire*

Is your low back / hip pain secondary to minor trauma? If yes, describe in detail: Yes / No

Do you have a history of cancer? If Yes, Describe: Yes / No

Have you recently experienced fever, chills or unexplained weight loss? Yes / No

Have you recently experienced a bacterial infection, IV drug use or immune system suppression from corticosteroids, transplant or HIV? Yes / No

Are you experiencing pain that cannot be made to feel worse or better with any specific movement or position? Yes / No

Is your low back /hip pain associated with symptoms in your legs? Yes / No
Describe in detail:

Is your low back / hip pain associated with a sudden onset of severe headache? Yes / No

Is your low back / hip pain associated with difficulty balancing or walking? Yes / No

Is your low back / hip pain associated with changes in bowel or bladder function? Yes / No

Is your low back / hip induced by coughing, sneezing, straining, or bending forward? Yes / No

Is your low back / hip pain associated with numbness or tingling in your groin and/or buttocks? Yes / No

What specifically aggravates your low back / hip pain?

☐Sitting	☐Standing	☐Coughing	☐Sneezing
☐Kneeling	☐Lying Down	☐Walking	☐Lifting
☐Computer Work	☐Driving Car	☐Chin to Chest	☐Looking at Ceiling
☐Rotating body to Left	☐Rotating Body right	☐Bending to Left	☐Bending to Right
☐Bowel Movements	☐Pushing		

☐Other, describe:

What specifically alleviates your low back / hip pain?

☐Nothing	☐Lying Down	☐Hot Packs	☐Cold Packs	☐Massage	☐Manipulation
☐Exercise	☐Stretching	☐Traction	☐Electrical Stimulation		☐Ultrasound

☐Medications, describe:
☐Resting in specific position, describe:
☐Other, describe:

How would you describe your low back / hip pain?

□Dull	□Aching	□Burning	□Sharp / Stabbing	□Electrical
□Pins / Needles	□Deep	□Superficial	□Tingling	□Numbing
□Other, describe:				

Does your low back / hip pain spread? Yes / No

If it spreads, where does it start and where does it go?

If it is pin-point pain, where is it?

On a scale of 1 to 10, 1 being very minimal pain and 10 being the worst pain you can imagine, circle how you would rate your low back / hip pain:

At its best: 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10
At its worst: 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10
On average: 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

What % of the time do you experience your low back / hip pain?

Daily: 0%----------25%----------50%----------75%----------100%
Weekly: 0%----------25%----------50%----------75%----------100%
Monthly: 0%----------25%----------50%----------75%----------100%

Does your low back / hip pain interfere with your ability to:

□Sleep, describe:

□Work, describe:

□Exercise, describe:

□Other, describe:

At what time of the day is your low back / hip pain at its worst?

At what time of the day is your low back / hip pain at its best?

Have you experienced this pain in your low back / hip before? Yes / No

History of Previous Evaluations / Treatments for Your Low Back / Hip Pain

Who have you seen previously for your low back / hip pain? Describe who, when, diagnosis and treatment previously received:

Have you received any special tests previously for your low back / hip pain i.e. MRI, X-ray? Describe:

Which previous treatment(s) did you find most beneficial?

Which previous treatment did you find least beneficial?

What do you think is causing your low back / hip pain?