

# LOW BACK PAIN EVALUATION FORM

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

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F MR# \_\_\_\_\_

Consultation/Referral requested by: \_\_\_\_\_

Employer / Case Manager: \_\_\_\_\_

## I. Presenting Hx:

1. Date & type of onset/ Progress: \_\_\_\_\_  Acute  Gradual  Chronic  Intermittent  Constant

2. Related to trauma? Yes No \_\_\_\_\_

3. Location of pain: R = L R > L L > R Other: \_\_\_\_\_

4. Type of pain: Sharp Aching Throbbing Burning Other \_\_\_\_\_

5. Intensity of pain: At onset – VAS /10 Present – VAS /10

6. Radiation to buttocks or legs: Yes No Describe \_\_\_\_\_

7. Muscle weakness: Yes / No \_\_\_\_\_ Leg numbness/ Pins & Needles: Yes / No \_\_\_\_\_

8. Bowel / Bladder Dysfunction: Yes / No (Describe) \_\_\_\_\_

9. Aggravating factors: \_\_\_\_\_

10. Relieving factors: \_\_\_\_\_

11. Previous back problems / Surgeries: (Describe) \_\_\_\_\_

12. Associated features:  Fever  Wt loss \_\_\_\_\_  ↑ Night pain  Other: \_\_\_\_\_

13. Functional limitations: \_\_\_\_\_

14. Hip / Knee symptoms: Yes / No \_\_\_\_\_

15. Work up: X-Ray \_\_\_\_\_

MRI \_\_\_\_\_

Other \_\_\_\_\_

16. Treatment received: Meds. \_\_\_\_\_

PT: Yes / No \_\_\_\_\_

Chiropractic manipulation: Yes / No \_\_\_\_\_

Injection: Yes / No \_\_\_\_\_

Other / Alternative therapy \_\_\_\_\_

17. Work status:  Off work  with restrictions  Full duty  On disability

II PMHx: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

III Social Hx: Work / Retired \_\_\_\_\_

Tobb: \_\_\_\_\_ ETOH: \_\_\_\_\_ Drugs: \_\_\_\_\_

IV Family Hx: \_\_\_\_\_

V Allergy: \_\_\_\_\_

VI Meds: \_\_\_\_\_

(For Physician Only)

Notes: \_\_\_\_\_

\_\_\_\_\_