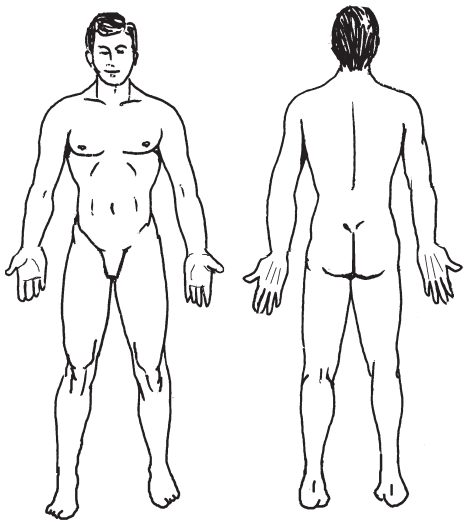
Patient Information

Baptist HEALTH

THERAPY CENTER BACK QUESTIONNAIRE

Name_____Doctor:_____Date:_____

PRESENT HISTORY:



1. When did the pain start?_____
2. How did the pain start? _____

PAIN SCALE (Circle) 0 = no pain 10 = worst pain

Please rate your highest level of pain over the past 30 days

0 1 2 3 4 5 6 7 8 9 10

Rate the level of pain in your back today (if applicable)

0 1 2 3 4 5 6 7 8 9 10

Rate level of pain in your leg(s) today (if applicable)

0 1 2 3 4 5 6 7 8 9 10

3. Where precisely did the pain start (draw it in with an “”X”)
4. Where is it now (currently/today?)_____
5. What makes it worse?_____

_____

6. Does it hurt at night? ❑ Yes ❑ No

6b. If yes, can the pain be affected by change in position or activity of any kind? ❑ Yes ❑ No

7. What is it like first thing in the morning?	Better	Stiff	Worse
8. What is it like mid day?	Better	Stiff	Worse
9. What is it like late afternoon?	Better	Stiff	Worse
10. What is it like in the evening?	Better	Stiff	Worse

11. What have you learned that makes your back better?_____

12. Are you currently off work because of your back pain? ❑ Yes ❑ No

If yes, since when?_____

13. Do you have any tingling, numbness or loss of skin sensation? ❑ Yes ❑ No If yes, where?_____
14. Have you experienced any clumsiness with your feet or weakness in your legs? ❑ Yes ❑ No If yes explain_____

_____

15. What treatments have you had? None or _____

Did they help? ❑ Yes ❑ No Other (explain)_____

16. Presently, are you getting _____better _____worse _____about the same.
17. Have you had anything similar before? ❑ Yes ❑ No If yes, describe:_____
18. Please list all conditions you are currently being treated for:_____
19. Please list all medical history/complications:_____

_____

20. Please list family history of medical/health complications: _____

_____

MISCELLANEOUS

21. List medications you are currently taking:_____
22. When do you see your physician next? _____
23. What concerns you most, your pain_____ or restriction of activities_____ both_____
24. What are your goals from physical therapy treatment? N/A Define those functional goals:

_____

Patient Signature: _____

PT 990