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? 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 suppression from corticosteroids, transplant or HIV? Yes / No

Are you experiencing pain that has no specific mechanical exacerbating or remitting factors? 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 changes in your gait? Yes / No

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

Is your low back/hip pain 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 to 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:

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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 it's best: 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10
At it's 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 it's worst?

At what time of the day is your low back/hip pain at it's 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?