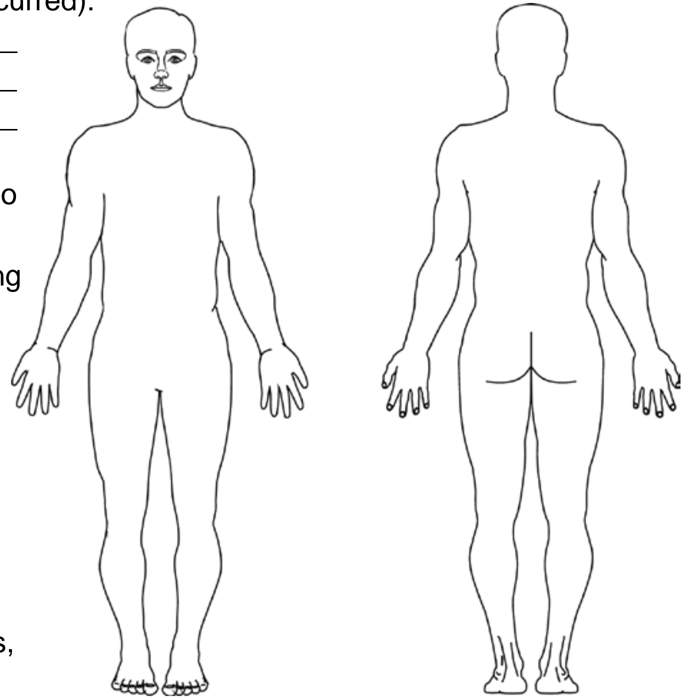
Patient Self History: Back Pain

Date:	Time:	
Patient Name (Last, First, MI)	Date of Birth (MM-DD-YYYY)	Medical Record # (for office use)

1. When did your pain begin? (Exact date preferred.) ____
2. Have you had similar symptoms before? ☐ Yes ☐ No If yes, how long ago? ____________________
3. Is your pain . . . ☐ Improving ☐ Getting worse ☐ Staying the same
4. Are your symptoms the result of an injury? ☐ Yes ☐ No (If No, skip to question 5.)
   If Yes, briefly describe your injury (how and where it occurred):
   ____
   ____
   ____
   Is this injury work related? ☐ Yes ☐ No
   Does this injury interfere with your work? ☐ Yes ☐ No
5. Using the symbols below, please mark the areas on your body where you feel the described sensations using the letters below. Please include all affected areas.

   A = Aching
   B = Burning
   S = Stabbing
   P = Pins and Needles
   W = Weakness
   N = Numbness



6. How would you rate your back pain in the past few days, using the scale below? ______/10

   0 = No pain 10 = extremely intense pain

   0------------1------------2------------3------------4------------5------------6------------7------------8------------9------------10

7. What makes the pain worse? Check all that apply.

☐ Sitting	☐ Sneezing	☐ Walking	☐ Mornings
☐ Bending	☐ Coughing	☐ Lying down	☐ Evenings
☐ Lifting	☐ Standing	☐ Twisting/turning	☐ Night

   What other things make your pain worse? ____

© Intermountain Healthcare 2013

8. What makes the pain better? Check all that apply.

☐ Sitting ☐ Standing ☐ Bending forward
☐ Lying down ☐ Walking ☐ Medication (please list): ____________________
☐ Exercise ☐ Walking with shopping cart

What other things make your pain better? ____

9. Do you exercise regularly? ☐ Yes ☐ No

10. Do you have any of these symptoms?

☐ Yes ☐ No Genital or rectal numbness
☐ Yes ☐ No Changes in bowel/bladder control
☐ Yes ☐ No Sexual dysfunction
☐ Yes ☐ No Fever or chills
☐ Yes ☐ No Sweating/night sweating
☐ Yes ☐ No Recent unexplained weight loss

11. Please answer the following questions.

☐ Yes ☐ No Do you smoke?
☐ Yes ☐ No Any history of alcohol abuse?
☐ Yes ☐ No Any other substance abuse?
☐ Yes ☐ No Do you feel afraid to exercise?
☐ Yes ☐ No Do you have insomnia?

12. Have you ever been diagnosed with any of the following?

☐ Yes ☐ No Cancer - Type: ________________
☐ Yes ☐ No Immunosuppression
☐ Yes ☐ No Osteoporosis
☐ Yes ☐ No Rheumatoid or juvenile arthritis
☐ Yes ☐ No Osteoarthritis
☐ Yes ☐ No Recent infection
☐ Yes ☐ No Bone fracture
☐ Yes ☐ No Fibromyalgia
☐ Yes ☐ No Headaches/migraines
☐ Yes ☐ No Other chronic pain: Where? ______
☐ Yes ☐ No Anxiety
☐ Yes ☐ No Bipolar Disorder
☐ Yes ☐ No Other: ______________________

*****NEW PATIENTS ONLY*****

13. Have you had any previous medical tests or treatments for your back pain?

☐Yes (complete table below) ☐No (skip table)

Tests			**Treatments**			
	Where	**When**		**Where**	**When**	**Was this treatment helpful?**
☐X-ray			☐Surgery			☐Yes ☐No
☐MRI			☐Spine injection			☐Yes ☐No
☐CT scan			☐Physical therapy/exercise			☐Yes ☐No
☐EMG (electromyelogram)			☐ Ice/heat			☐Yes ☐No
			☐Chiropractor			☐Yes ☐No
☐Bone density exam			☐Back brace			☐Yes ☐No
			☐Massage			☐Yes ☐No
☐Other:			☐Other:			☐Yes ☐No

14. Have you talked with an attorney about the cause of your back pain? ☐ Yes ☐ No

Patient Self History: Back Pain

CPM009a - 03/08/13 Patient and Provider Publications 801-442-2963
© Intermountain Healthcare 2013