Neurosurgical Associates at St Francis

Medical History Questionnaire for Low Back Pain

Patient's name ______________________ **D.O.B.** ______________ **Age** ________

Was there an accident or injury that you are aware of? ______________________

When did your symptoms begin? ______________________

Describe your symptoms ______________________

Do you have leg pain? ☐ Y ☐ N **Numbness or Tingling?** ☐ Y ☐ N **Which leg?** ☐ R ☐ L ☐ Both

Describe ______________________

Have you had any changes with your bowel or bladder habits, if so explain? ______________________

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Have you noticed any changes in your walking? ☐ Y ☐ N **Describe** ______________________

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What improves your pain? ______________________

What aggravates your pain? ______________________

Have you had Physical Therapy or seen another physician for this problem? ☐ Y ☐ N **if yes, who / where?** ______________________

What testing have you had? (please check) ☐ MRI ☐ CT ☐ Myelogram ☐ EMG ☐ Discogram ☐ Selective Nerve Root Block ☐ plain x-rays ☐ other ______________________

What treatment have you received? (please check) ☐ Physical therapy ☐ Bedrest ☐ Chiropractic ☐ Anti-inflammatory medicines ☐ Epidural injections ☐ other ______________________

Are your symptoms getting worse, improving, or staying the same? ______________________

On a scale of 1-10 with 10 being the worst possible pain, please rate your pain ______________

Factors That May Affect Learning

Who is to be taught?: ☐ patient ☐ other; if other, relationship to patient ______________________

Able to read?: ☐ yes ☐ no ☐ with difficulty Comments ______________________ **Potential barriers to learning**: ☐ none ☐ blind ☐ poor vision ☐ deaf ☐ decreased hearing ☐ unable to talk ☐ learning disability ☐ inability to understand ☐ memory loss ☐ language, if other than English ______

Learns best by: ☐ reading ☐ verbal instruction ☐ practicing ☐ talking ☐ watching ☐ other, __________

Are there any cultural or religious beliefs that need to be considered in the care? ☐ yes ☐ no if yes, ______________________

Signature ______________________ **Relationship to patient** ______________ **Date** ________

Staff review date & initials ______________