BRAIN & SPINE CENTER
MEMORY CLINIC
Diagnose Modify Treat

Brain and Spine Center, P.L.C.

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BACK PAIN QUESTIONNAIRE

Please check the box(es) that pertain to you.

Patient name: _____ **Date:** _____

Location: ☐ Back ☐ Hips ☐ Gluteus ☐ Spine Other: _____

Characteristic: ☐ Throbbing ☐ Pressure-like ☐ Jabbing ☐ Shooting Other: _____

Pain radiates to: ☐ Hips ☐ Gluteal area ☐ Groin ☐ Thigh ☐ Ankle ☐ Feet
Other: _____

Frequency: ☐ 1/week ☐ 2-3/week ☐ More than 3/week

Pain lasts for: ☐ Few seconds ☐ Minutes ☐ Hours

Worsened by: ☐ Coughing/Sneezing ☐ Activity ☐ Sitting ☐ Standing ☐ Walking
Other: _____

Improved by: ☐ Rest ☐ Lying down ☐ Sitting down Other: _____

Bladder and bowel incontinence: ☐ Yes ☐ No

Medications tried in the past

☐ Neurontin ☐ Lyrica ☐ Baclofen ☐ Zanaflex ☐ Flexeril

Other: _____

Have you had any of the following?

Back injection	**Physical therapy**	**Nerve blocks**
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

MRI L-Spine	☐ Yes ☐ No	If yes: When/Where _____
Physical therapy	☐ Yes ☐ No	If yes: When/Where _____
Surgery	☐ Yes ☐ No	If yes: When/Where _____