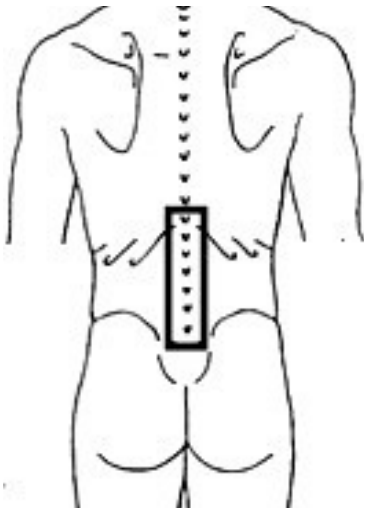
Your Name:_____ Today's Date:_____

Part 1: Back Pain

Do you have pain in the Midline of your back (*inside the black rectangle*)?

☐No If No, go to Part 2

☐Yes If Yes, please draw 1 or more X's inside the black rectangle to indicate where your pain is.



This Pain: ☐ Is constant (always present, never *completely* goes away)

☐ Comes and goes, stays for: ☐ Seconds ☐Minutes ☐Hours ☐Days

Score this pain level from 0 to 10 (*0 is no pain, 10 is the worst pain imaginable)*

Right now:____ At its worst:____

Check 1 or 2 boxes that best describe this pain:

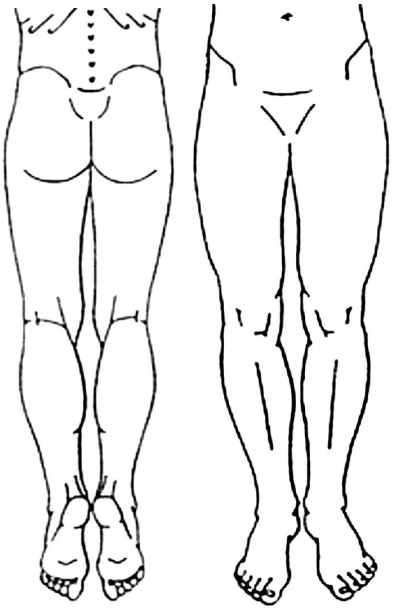
□ Sharp □ Shooting □ Stabbing □ Aching □ Dull □ Sore □ Burning
□ Pressure □ Pinching □ Squeezing □ Tightness □ _____

Part 2: Radiating Back Pain to the Legs

Does your pain radiate to the side or down your leg(s)?

☐ No If No, skip this box

☐ Yes If Yes, please draw arrow(s) to indicate where your pain radiates from and to.



This radiating pain:

☐ Is constant (always present, never *completely* goes away)

☐ Comes and goes, stays for: ☐Seconds ☐Minutes ☐Hours ☐Days

Score this radiating pain level from 0 to 10

(*0 is no pain, 10 is the worst pain imaginable)*: Right now:___ At its worst:____

Check 1 or 2 boxes that best describe this radiating pain:

□ Sharp □ Shooting □ Stabbing □ Aching □ Dull □ Sore □ Burning
□ Pressure □ Pinching □ Squeezing □ Tightness □ _____

My pain is worse with:

☐ Standing ☐ Walking ☐ Computer work
☐ Driving ☐ Looking up ☐ Bending
☐ Lying ☐ Lifting ☐ Sitting ☐ Sneeze or Cough
☐ Getting out of chair/bed/car ☐ Turning Head
☐ Change in weather ☐ Other_____

My pain is improved with:

☐ Sitting ☐ Bending ☐ Heat
☐ Lying ☐ Standing ☐ Stretching
☐ Walking ☐ Meds: _____
☐ Other_____
_____