Patient Back Pain Index Intake

Name: **DOB:**
Address: **Phone #:**
E-mail: **Insurance Name:**
Provider Name: **Insurance Member ID #:**
Provider Phone #: **Estimated Due Date:**
Height: **Weight:** **Number of Weeks/day's:**

1. How many weeks have you been experiencing your present problem? _____

2. Have you experienced similar pain in the past? □ No □ Yes If yes, when? _____

3. How did your pain begin? (Check all that apply)

□ Suddenly	□ Gradually	□ Lifting	□ Bending	□ Accident
□ No known cause	□ Twisting	□ Pulling	□ After a fall	□ Injury

4. What activities make your pain worse? (Check all that apply)

□ Lying	□ Standing	□ Sitting	□ Walking
□ Exercise	□ Bending	□ Twisting	□ Coughing

5. On a numeric pain scale 10 being the worst pain ever experienced, how would you rate your pain on a scale of 1 to 10? _____.

6. Have you experienced any of the following? (Check all that apply)

□ Excessive weight gain ***(O99.210) obesity complication pregnancy***	□ Fatigue ***(O26.819)***	□ New balance problems ***(R26.81)***
□ Loss of bladder control ***(O26.89)***	□ Difficulty walking ***(R29.89)***	□ Swelling (legs/arms) ***(O12.00)***
□ Center of gravity out of alignment ***(M43.8X7) sagittal plane imbalance***	□ Pain in the back, buttocks, hip or legs ***(M54.40) lumbago with sciatica***	□ Lower back pain ***(M54.50)***
□ Pain radiating down legs described as any of the following: Burning/stinging/numbness/ tingling/weakness ***(M54.10) radiculopathy***	□ Large inward arch above buttocks and pendulous/distended abdomen ***(M40.46) lordosis***	□ Lower abdomen pain near hip and groin. Sharp stabbing or aching **(*O26.899) round ligament pain***

7. Failed Conservative Treatments for how many weeks? _____

□ OTC Medication	□ Physical Therapy	□ Acupuncture
□ Ice/Heat application	□ Stretches/Home Exercise	□ OTC Supports

8. Prior history of: (please upload any reports from any imaging such as Xray, CT and MRI)

□ Back Pain	□ Previous Back Surgery	□ None
□ Scoliosis	□ Disc Pathology	□ Herniation
□ Fracture	□ Spondyhlolithesis	□ Spinal Stenosis

Patient Signature: _____ Date: _____